STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166299	A. BUILDING _____ B. WING _____	12/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW ACRES	1485 GRAND MARION, IA 52302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS OK TAKE Correction date: 1/31/2020 The following deficiencies relate to the recertification survey and investigation of Complaints #87385, #87483,#87552, #87564, #87599 and a facility Self Reported Incident #87551 completed 12/16-24/2019. (See Code Federal Regulations (42CFR) Part 483. Subpart B-C).	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff interview the facility failed to provide an accessible call light for 1 of 18 residents, (Resident #13) The facility identified a census of 74 residents. Findings include: The Admission Record identified resident #13 admitted on 2/26/19 with a primary diagnosis of multiple sclerosis. The Minimum Data Set (MDS) Assessment, dated 9/11/19, showed a Brief Interview for Mental Status (BIMS) score of 11 indicating minor cognitive loss. The resident required full staff assistance with bed mobility, transfer, dressing,	F 558		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 1-17-2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 558	Continued From page 1 personal hygiene, toileting and utilized a suprapubic urinary catheter. The resident required use of a wheelchair and did not ambulate. During an interview on 12/16/19 at 2:34 p.m. the resident reported he/she has to ask his/her roommate to put on their call light when he/she needs help. The resident stated during the day he/she can propel his/her wheelchair out into the hallway to ask for help or can ask the roommate to put the call light on. The resident stated when he/she is in bed, he/she has to wake up his/her roommate to put the call light on for help or he/she has to yell for help. The resident stated he/she does not like to wake up the roommate at night. The resident stated he/she does get help during the night, but it is an inconvenience not to have a call light to directly call for assistance. During an observation on 12/16/19 at 7:35 p.m. the resident sat in the wheelchair in the room watching television. The room call light lit up outside the room to indicate the resident needed assistance. During an observation on 12/16/19 at 8:11 p.m. the resident lay resting in bed with no call light in reach, as the call light lay in the roommate's chair. During an observation on 12/17/19 at 4:24 p.m. the resident lay in bed without the call light in reach, while the call light laid in the roommate's chair. During an interview on 12/19/19 at 9:40 a.m., Staff DD, Certified Nursing Assistant, (CNA), reported the resident should have a call light in	F 558		

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F 558	Continued From page 2 reach when in bed. Staff DD walked into the resident's room and verified the resident's room only had one functioning call light that lay in the roommate's recliner. Staff DD put the call light on and the call light did not light up outside the resident's room with three attempts to use the call light. Staff went to get the Administrator. Staff DD reported the room call light had been on earlier in the morning. During an interview on 12/19/19 at 10:45 a.m., the Administrator verified the room had one call light and the call light did not light up outside the room. The Administrator had Maintenance Staff come to the resident's room. During an interview on 12/19/19 10:48 a.m., Staff EE, Maintenance, stated he had wired the resident # 13's call light over the room door way to the roommates recliner and knew the room only had one functioning call light. He reported the call light in the room had been broken by the roommate at least four times prior and he had repeatedly fixed the call light in the room resulting in Resident #13's call light being hooked up over the room doorway to go to the roommates recliner. The other call light on the roommates side of the room had been wired up to the wall and did not work. The Maintenance Work Order, provided by the facility, showed the call light in the resident's room had been repaired on 11/25/19, 11/27/19, 12/7/19 and 12/11/19. The Maintenance Work Order showed the call light had been wired to the wall on 11/27/19. During an observation at 12/19/19 at 10:50 a.m., the Administrator and Staff EE replaced the call	F 558		

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F 558	Continued From page 3 light set up to accommodate two working call lights and rearranged the resident's room to accommodate access of the call lights. During an interview at 12/19/19 at 10:51 a.m. the Administrator verified the call lights in the room were working. During an interview at 12/19/19 at 11:35 a.m. the Director of Nursing (DON) reported resident's should have call lights in reach to be able to call for assistance. The undated Call Light Policy, provided by the facility outlined a procedure for staff including: a. When providing care to residents be sure to position the call light conveniently for the resident to use. b. Tell the resident where the call light is and how to use the call light. c. Be sure call light are placed within resident reach at all times, never on the floor or bedside stand.	F 558		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F 584		

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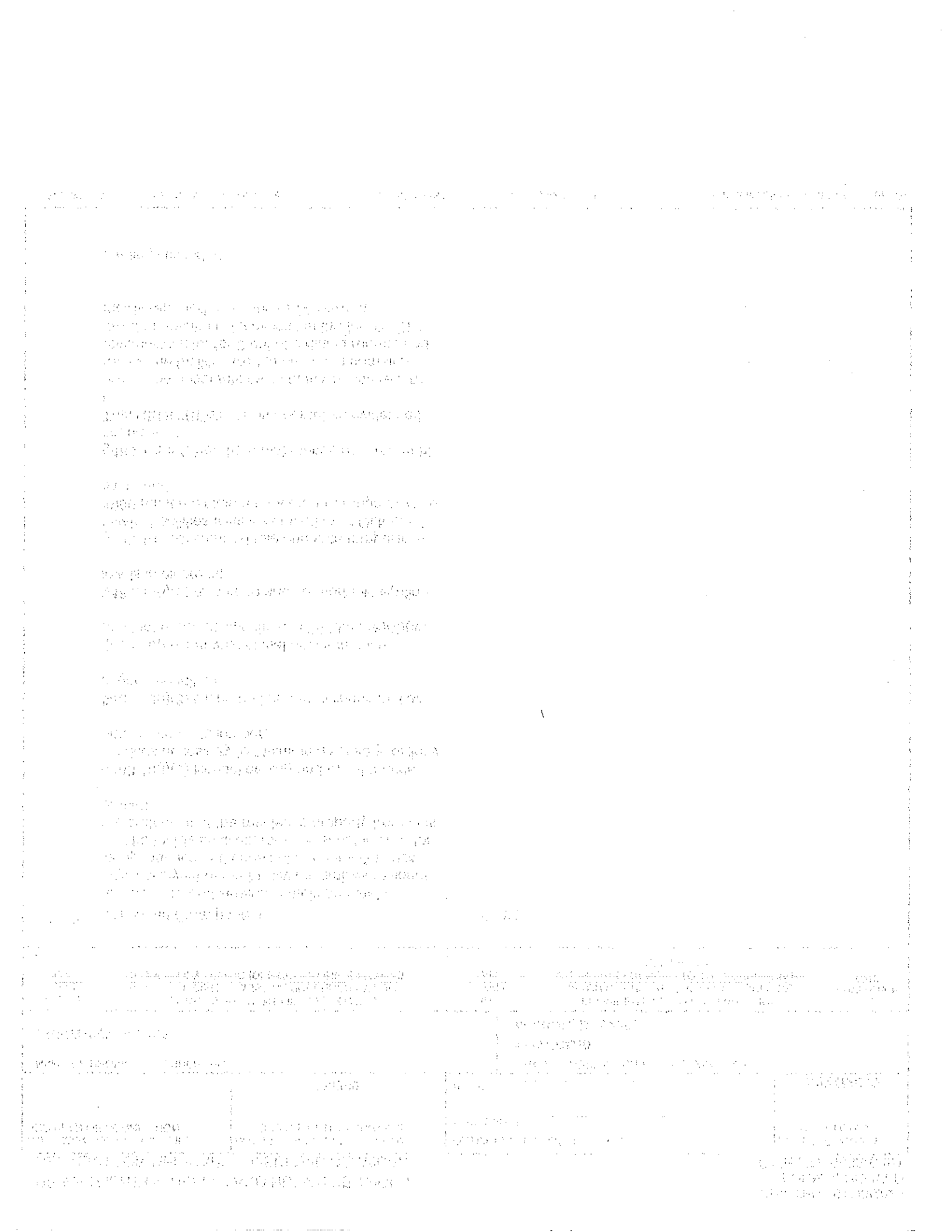
F 584	Continued From page 4 receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the facility failed to provide a homelike environment for for 2 out of 2 dining rooms, and failed to maintain cleanliness in the facility. The facility reported a census of 74 resident. Findings included:	F 584		



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F 584	Continued From page 5 1. During random observations of the bird cage in the 400 hall the following noted: a. On 12/17/19 at 8:17 a.m., the bird cage contained white splatters on all 12 windows. b. On 12/18/19 at 8:45 a.m., the 12 windows in the bird cage continued with white splatters. c. On 12/23/19 at 7:27 a.m., the bird cage remains with white spatters on all 12 window. 2. During observations of the Unit the following issues identified: a. On 12/16/19 at 10:45 a.m., revealed several dry brown spots on the floor just inside the door with foot prints all the way down the hall. b. On 12/18/19 at 8:30-8:40 a.m., shoe prints remain all the way down the 200 hall into the dining room, the floor in the unit dining room has brown spots and splashes randomly all over the floor, and particles of white and brown debris random all over the floor in the dining room. At the dining room entry way 7 dark brown spots on the floor. c. On 12/19/19 8:13 a.m., the several dry brown spots on the floor just inside the door remained with foot prints all the way down the hall. The floor in the Unit dining room contained brown, white crumbs and debris and the brown spots at the entry way to the dining room remain. d. On 12/23/19 08: a.m., the several dry brown spots on the floor just inside the door remained with foot prints all the way down the hall. The floor in the Unit dining room contained brown, white crumbs and debris and the brown spots at the entry way to the dining room remain 3. During observations of the main and the unit dining rooms within the facility shown the following:	F 584		

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F 584	Continued From page 6 a. On 12/17/19 at 12:15 p.m., all 13 residents in unit eating the meal off trays. b. On 12/18/19 at 8:26 a.m., 12 residents at the tables in the main dining room eating off trays. c. On 12/19/19 at 8:38 a.m., 11 residents eating off trays in the unit dining room. d. On 12/19/19 at 8:41 a.m., 21 residents eating off trays in the main dining room. During an interview on 12/23/19 at 8:33 a.m., the Housekeeping/Laundry Interim Supervisor, reported the expectation is the floors are swept and mopped on a weekly basis. Pointed out the spots and debris on the 200 hall and the 200 dining room. The Housekeeping/Laundry Interim Supervisor stated the expectation is the 3 housekeepers on in the day and the 2 evening housekeepers daily keep the building clean. The Housekeeping/Laundry Interim Supervisor confirmed the building needs work done. During an interview on 12/23/19 at 9:06 a.m., the Housekeeping/Laundry Interim Supervisor stated the bird cage is rented and they come 2 times a month to care for the birds. During an interview on 12/23/19 at 9:55 a.m., the Dietary Manager reported the trays are used because it's easier for the staff to deliver and pick up the food and drinks on the trays. 4. During an interview on 12/17/19 at 12:48 p.m., Staff A and B, both Certified Nursing Aides (CNA's) reported resident's rooms do not always get cleaned every day, sometimes it is every other day, sometimes it is just when housekeeping can get to it. They both noted there has been a big turn over in housekeeping staff. They remarked there is a new Housekeeping Supervisor, so hopefully things will	F 584		

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F 584	Continued From page 7 change for the better. Both staff persons agreed the environment and resident's room do not look as clean, as they should. The undated Housekeeping Policy, directed at point # 3 all rooms, corridors, storage areas, linen closets shall be kept in a clean, orderly condition, free of unserviceable furniture and equipment and accumulation of refuse.	F 584		
F 585 SS=B	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy	F 585		

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F 585	Continued From page 8 to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by	F 585		

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F 585	Continued From page 9 anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, Resident Group interview, staff interview, and record review the facility failed to inform staff and residents about the facility's Grievance Policy, failed to inform them how to file a grievance, and failed to follow up on resident concerns. The posted facility's Grievance Policy failed to identify a Grievance Officer. The facility identified a census of 74 residents. Findings include: 1. Observation upon entrance to the facilty on	F 585		

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F 585	Continued From page 10 12/16/19 at 9:00 a.m., revealed a posted Grievance Policy/Procedure on the wall across from the front Nursing Station. The Grievance Policy failed to identify a named Grievance Official. There were Grievance/Complaint Forms placed below the Policy for use. A Resident Group Interview on 12/16/19 at 1:00 p.m., conducted with 5 interviewable residents deemed by the facility. 5 of 5 residents reported unaware of the Grievance Policy. All 5 residents in attendance reported they did not know how to file a grievance, and unaware which staff person represented the Grievance Official. Resident # 60 reported not knowing about having a named Grievance Official, but felt they should have one person designated. The 5 residents in the group also reported concerns reported to include cold food and not enough condiments on the tables in the dining room, and cold food on room trays with no condiments at all. The entire group felt the food served tasted cold most of the time. They reported condiments were present for awhile after they expressed their concern, but now, lately, they were not available, except the room trays never have had condiments present. They expressed concerns that bedtime snacks were not always passed, and would like them to be passed. They remarked feeling the facility staff were not listening to them. During an interview on 12/18/19 at 11:55 a.m., 3 Certified Nursing Aides (CNA's) Staff L, Staff F and G reported unaware the facility had a Grievance Policy, except one CNA remarked there were forms to use up by the front Nursing Station. All 3 CNA's reported not aware which	F 585		

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F 585	Continued From page 11 staff appointed the Grievance Official, but one CNA (Staff G) remarked it probably would be the Administrator. During an interview on 12/17/19 8:02 a.m., the Administrator reported the residents can give a concern to any nurse and then it trails back to her. When asked if a staff member assigned as the Grievance Official, the Administrator hesitated and said, well, it comes back to me. During an interview on 12/18/19 at 1:10 p.m., the Nurse Manager (Staff H), reported not aware of the facility's Grievance Policy. She noted the Social Worker would probably be the acting Grievance Official. During an interview on 12/18/19 at 1:30 p.m., the designated Social Worker (SW) reported not knowing the residents and staff unaware the facility had a Grievance Policy and remarked "that wasn't good". She did not believe that Policy had been brought up at the Resident Council Meetings, but would make sure that happened. When asked who was the Grievance Official, she remarked she did not really know. The SW reported they do try to address resident's concerns and follow up from the Resident Council Meeting. Review of the Resident Council Meeting minutes for 10/2019 included the following: a. No snacks, staff had to go to the kitchen for snacks, cold and late lunches- which Dietary said they were working on this concern and the Administrator noted this would take time to get things straightened out. b. Dietary reported to start delivering room trays with condiments.	F 585		

[illegible]

[illegible] appear [illegible] [illegible] [illegible] [illegible] [illegible]

During [illegible] the [illegible] reported [illegible] [illegible] When [illegible] [illegible] [illegible] [illegible]

During [illegible] (Staff [illegible] [illegible] [illegible] [illegible] whether [illegible] and possibly [illegible] [illegible]

During [illegible] [illegible] [illegible] the [illegible] [illegible] brought up at the Resident [illegible] [illegible] [illegible] was the [illegible] [illegible] she [illegible] [illegible] [illegible] [illegible] [illegible] the Resident [illegible] [illegible]

[illegible] included the following: [illegible] [illegible] [illegible] [illegible] [illegible]

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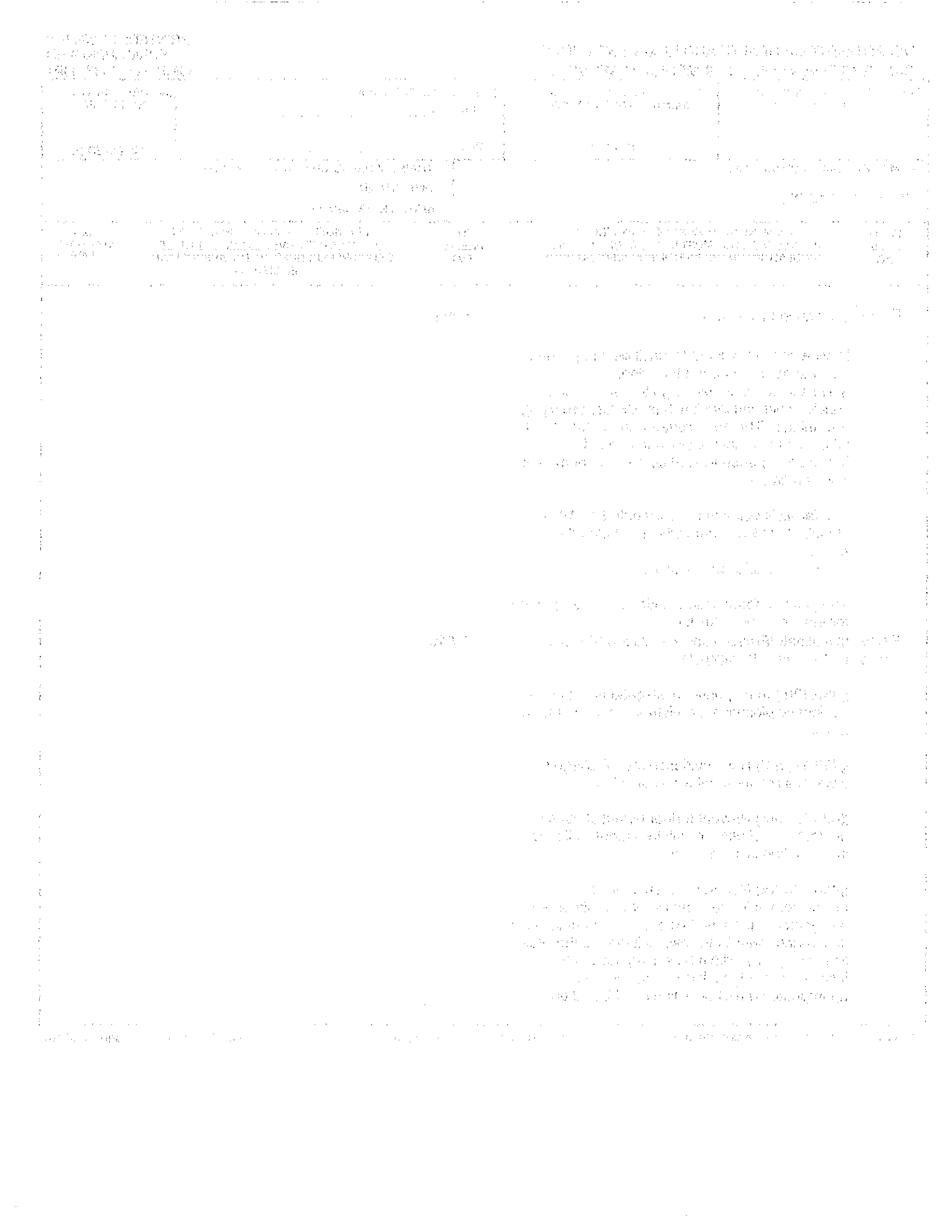
F 585	Continued From page 12 Review of the Resident Council Meeting minutes for 11/2019 included the following: a. No snacks, staff had to go to the kitchen for snacks, cold and late lunches- Dietary are trying new things. The Administrator noted this would take time to get things straightened out. b. Dietary reported to start delivering room trays with condiments. The facility's Grievance Policy dated 12/19/16 identified the Procedure which included the following: 1. Identify a Grievance Official. The posting found failed to identify a staff person for the Grievance Official.	F 585		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 610		



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F 610	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on resident, staff interviews, and record review the facility failed to provide a thorough investigation for an alleged physical abuse with dignity concerns as reported by a complainant and facility reported incident. The facility failed to interview the alleged staff involved for the possible abuse in a timely manner. The facility identified a census of 74 residents. Findings include: 1. Resident # 69's (closed record) Minimum Data Set (MDS) assessment dated 11/18/19 identified the resident with short and long term memory loss. The resident's diagnoses included diabetes, end stage renal disease, and received dialysis treatment. The facility's Administrator sent an Incident Report to the Department of Inspection and Appeals (DIA) on 11/22/19 for an allegation of Abuse which occurred 11/17/19. Resident #69 accused Staff C and D, both Certified Nursing Aides (CNA's) from an agency. A report completed by the Administrator for the investigation showed statements from staff, assessment done by the Director of Nursing (no longer employed at the facility), statements from residents and staff regarding dignity and questions of the 2 CNA's involved. The Incident Intake Information from the DIA Office regarding this concern reported by the facility is dated 12/12/19. The intake included attached review and findings. The Intake Form also stated the statements from the Agency	F 610		

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F 610	Continued From page 14 (where the alleged Aides were employed) were still pending. During an interview on 12/17/19 at 1:15 a.m., the 2 Agency Staff (Staff C and D) reported they just heard about the alleged abuse from the resident regarding the possible abuse this morning from the Agency. During an interview on 12/18 19 at 9:45 a.m., the Administrator reported calling the Agency multiple times since the incident to get statements from the 2 Agency Aides with no results received. During an interview on 12/19/19 at 11:45 a.m., the Administrator reported she never called the 2 CNA's personally to get an interview or statements from them. She thought the previous Director of Nursing (DON/Staff P) had informed them of the accusation. During an interview on 12/18/19 at 2:26 p.m.,the Staffing Agency Manager (Staff O) reported he received a call from the DON, Staff P, requesting a DNR, meaning Do Not Return to the facility. The previous DON did not state a reason and remarked she would be calling back, but then she never did. Staff O did not know the 2 CNA's from the Agency were alleged with abuse. He remarked he sure would have wanted to know that important fact. He also remarked no one from the facility called him to inquire until 12/17/19. He remarked his assistant did receive a call in the past (unknown time frame) from the facility, but failed to explain the reason for the call. His assistant forgot to give him that message, to return the call to the facility. On 12/19/19 at 11:45 a.m., the Administrator	F 610		

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F 610	Continued From page 15 brought in the statement received by the Staffing Agency Manager with his investigation with the 2 CNA's from the agency. Review of the facility's Abuse Prevention, Identification, Investigation, and Reporting Policy revised on 4/1/17, directed on page 7 the following for Investigations: a. The Administrator or designee will complete documentation of the allegation of Resident abuse and collect supporting documents relative to the alleged incident. b. Obtain witness statements (oral and /or written) from all known witnesses.	F 610		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		

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F 657	Continued From page 16 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review the facility failed to update 3 out of 18 resident Care Plans reviewed for residents with condition changes (Resident # 5,# 44, #63). The facility reported a census of 74 residents. Finding included: 1. The Minimum Data Set (MDS) assessment for Resident # 63 dated 11/14/19, listed a diagnosis of cancer. The MDS further listed the Resident with a Brief Interview of Mental Status (BIMS) of 14 indicating intact cognition. The Treatment Administration Record (TAR) dated 12/9/19, directed staff to apply Triamcinolone Acetonide Cream 0.1 % (Triamcinolone Acetonide) to the resident's abdomen topically two times a day for raised red rash to site until healed. The Care Plan for Resident # 63 dated 12/18/19 lacked any identification of the rash on the resident abdomen. During an interview on 12/18/19 at 12:29 p.m., the MDS Coordinator acknowledged the need to update the residents' Care Plans as soon as possible. 2. Resident # 5's Minimum Data Set (MDS) assessment dated 11/29/19 showed the resident	F 657		

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F 657	Continued From page 17 with no memory deficits, required extensive staff assistance for toileting, always incontinent with bladder functions, and did not have a catheter. During an observation on 12/16/19 at 11:04 a.m., 2 Certified Nursing Aides (CNA), one in orientation and Staff I performed peri cares for the resident. The resident noted without a catheter. The resident's Care Plan initiated on 12/8/16 and revised on 11/20/19 identified the resident with an altered pattern of urinary elimination related to a catheter placement and included interventions for this concern. A Physician's Order dated 12/6/18 showed the discontinuation of the Foley catheter. During an interview on 12/19/19 at 1:20 p.m., the Director of Nursing (DON) reported the MDS Coordinator fairly new and working on updating the Care Plans, but she is only here 3 days a week, and this has been taking awhile. 3. The Minimum Data Set (MDS) Assessment, dated 10/24/19, for resident #44 showed the resident with short and long term memory impairment and did not exhibit behaviors. The resident required extensive assistance with bed mobility, transfer, dressing, toileting and personal hygiene. The MDS listed diagnoses of Non-Alzheimer's Dementia, anxiety, depression, and senile degeneration of the brain. The resident received Hospice Care services. A Bed safety Assessment form, dated 11/6/19, showed the resident had two side rails attached to the resident's bed.	F 657		

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F 657	Continued From page 18 A Side Rail Risk Assessment, dated 11/21/19, identified the resident utilized side rails. A Order Audit Report, provided by the facility, dated of 12/19/19, identified a Nursing Order for a wanderguard every shift placed for the resident on 12/10/14 and discontinued on 9/21/19. The Progress Notes, provided by the facility, dated from 9/1/19 thru 12/19/19, identified the resident used a wanderguard and the device discontinued on 9/19/19. A Order Audit Report, provided by the facility, dated 12/19/19, identified the resident with a Nursing Order for a bed alarm dated 1/19/18 and discontinued 9/26/19. A Care Plan, with a revision date of 2/6/18, identified the resident at a risk of injury, with a history of previous falls, wanders aimlessly and is disoriented to place. The Care Plan directed the staff to alarm the bed, effective 8/17/16 and utilize a wanderguard at all times, effective 10/27/14. The care plan did not address the resident's use of side rails to the bed. During the following observations, noted the resident without a wanderguard in place: a. On 12/17/19 at 8:15 a.m., sitting in a wheelchair in the dining room. b. On 12/17/19 at 1:15 p.m., the resident lay in bed supine with half side rails up on each side of the bed without a bed alarm in place. c. On 12/17/19 at 3:30 p.m., the resident lay in bed supine with half side rails up on each side of the bed without a bed alarm in place. d. On 12/18/19 at 12:30 p.m., sitting in a high back wheelchair at the dining room table.	F 657		

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F 657	Continued From page 19 e. On 12/18/19 at 1:45 p.m., the resident lay in bed supine with half side rails up on each side of the bed, without bed alarm in place. f. On 12/19/19 at 7:45 a.m., sitting in a wheelchair in the dining room. During an interview on 12/18/19 at 10:50 a.m., Staff AA, Oral Medication Technician (OMT) and Certified Nursing Assistant (CNA) reported the staff should follow the task sheets and Care Plan to know how to take care of a resident. During an interview on 12/19/19 at 7:59 a.m. Staff V, CNA, reported the resident did not have a bed alarm on the bed and did not wear a wanderguard. She stated the resident had not used the bed alarm or wanderguard for some time, but did not know when the devices had been discontinued. During an interview on 12/19/19 at 9:40 a.m., the Minimum Data Set (MDS) Coordinator and Nurse Consultant verbalized the CNA task sheet and Care Plan listed the wanderguard and bed alarm which were discontinued by the MDS Coordinator as of today, 12/19/19 and confirmed resident #44's Care Plan not properly revised. During an interview on 12/19/19 at 11:45 a.m. the Interim Director of Nursing (DON), reported they had discussed the resident's use of the bed rails last night and they are assessing options on what to do at this point. No updates have been done to the Care Plan regarding the resident's use of the side rails. She stated the new MDS Coordinator started in August and is trying to go through all the Certified Nursing Assistant Task Sheets and Care Plans to bring up to date. She acknowledged that the Care Plans are not up to	F 657		

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F 657	Continued From page 20 date to communicate care needs and the facility is working on it. During an interview on 12/23/19 at 1:32 p.m. the Interim DON reported the facility did not have a Care Plan Policy.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff interview, the facility failed to follow a physician order for continuous oxygen and clarify a physician order for wound treatment for 2 of 7 residents reviewed. (Resident #30 and#35) The facility identified a census of 74 residents. Findings include: 1. The Minimum Data Set (MDS) Assessment dated 10/3/19 for resident #30 showed the resident with a Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment. The resident required extensive assistance for bed mobility, transfer, ambulation in the room and locomotion via wheelchair to the dining room. The MDS listed diagnoses of heart failure, hypertension, renal insufficiency, diabetes mellitus, Non-Alzheimer's Dementia, anxiety and Chronic Obstructive Pulmonary Disease (COPD). An Order Review Report, signed by the physician	F 658		

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F 658	Continued From page 21 on 12/10/19, showed a physician order for oxygen continuous at four liters every shift for prophylaxis related to COPD. A post-hospitalization visit progress note, signed by the Advance Registered Nurse Practitioner (ARNP) 10/9/19, showed the resident hospitalized from 9/29/19 - 10/3/19 for acute chronic respiratory failure secondary to COPD and assessment revealed the resident with shortness of breath. The ARNP ordered for the oxygen to continue at four liters per minute by nasal route continuously. A Care Plan with an initiation date of 2/19/19 identified the resident used continuous oxygen. The Treatment Administration Record for November and December 2019, provided by the facility, showed a Physician Order for oxygen at 4 liters continuous signed off by staff. During an observation on 12/17/19 at 8:28 a.m., the resident sat in the wheelchair at the dining room table and requested to go back to his/her room. Staff DD, Certified Nursing Assistant (CNA), shut off the resident's oxygen concentrator, unplugged and coiled the cord on the oxygen concentrator. Staff DD escorted the resident via wheelchair approximately 150 feet back to the resident's room without continuous oxygen on as per the physician order. The resident without a portable oxygen tank on the wheelchair. During an observation on 12/17/19 at 11:33 a.m., Staff DD escorted the resident via wheelchair approximately 150 feet from the resident's room to the dining room without portable oxygen	F 658		

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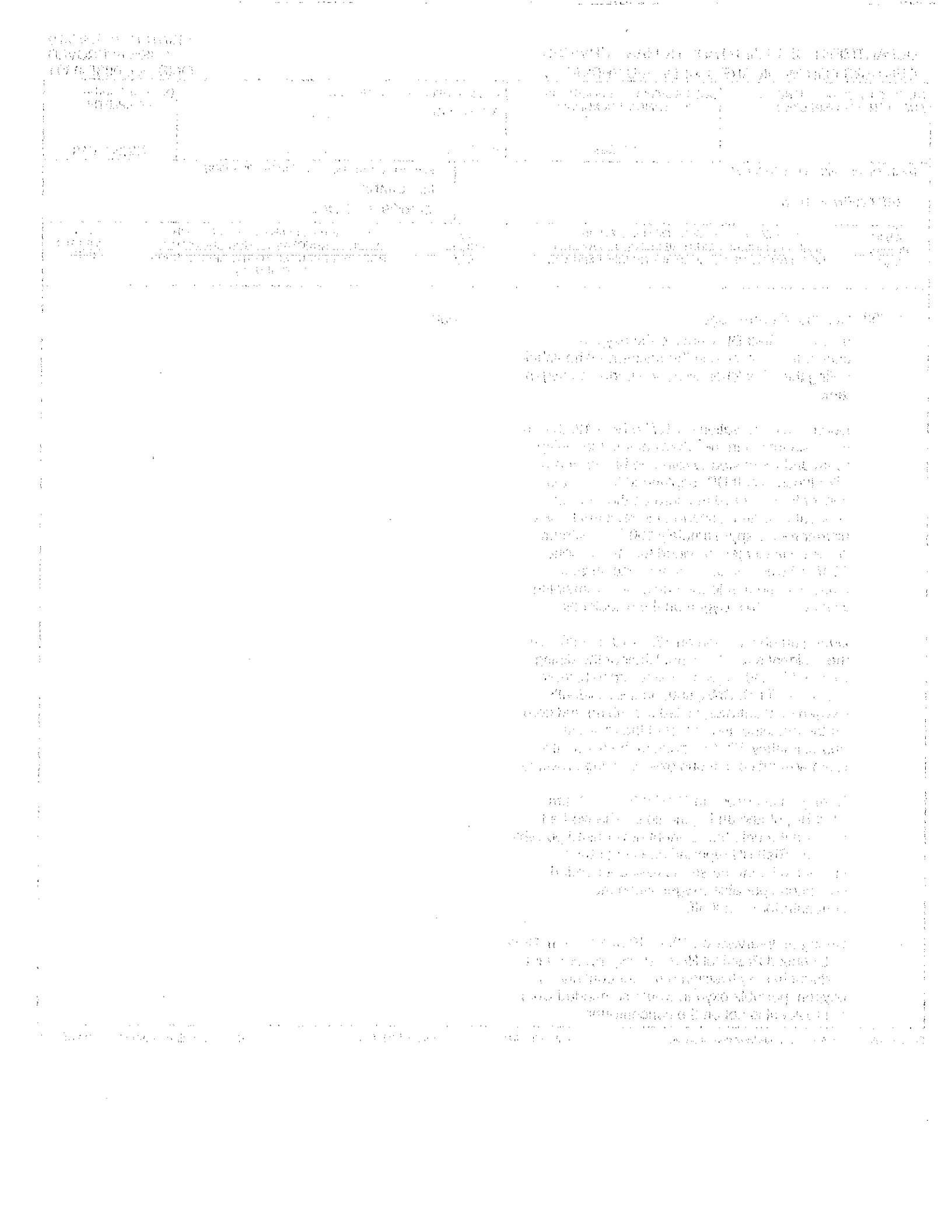
F 658	Continued From page 22 provided. Staff DD wheeled the oxygen concentrator alongside the resident's wheelchair, noting the wheelchair without a portable oxygen tank. During an observation on 12/17/19 at 12:28 p.m., the resident sat in the wheelchair in the dining room and requested to return to his/her room after lunch. Staff DD unplugged the oxygen concentrator, coiled the cord on the oxygen concentrator and escorted the resident back to his/her room, approximately 150 feet, without continuous oxygen provided for the resident. Staff DD wheeled the oxygen concentrator alongside the resident's wheelchair, remaining with no portable oxygen on the wheelchair. During an observation on 12/18/19 at 9:06 a.m., the resident sat in the wheelchair at the dining room table and requested to return to his/her room. Staff BB, CNA, shut off the resident's oxygen concentrator, coiled the tubing and cord on the machine and escorted the resident approximately 150 feet back to the resident's room without continuous oxygen being provided. During an interview on 12/18/19 at 9:12 a.m., Staff BB, stated during the times she worked back on the unit, the resident never used portable oxygen. Staff BB reported she never been instructed by the nurse the resident needed continuous portable oxygen when the concentrator is shut off. During an interview on 12/18/19 at 1:55 p.m. Staff Z, Licensed Practical Nurse (LPN), reported if a resident has a physician order for continuous oxygen, portable oxygen would be needed when the resident is not on the concentrator.	F 658		



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F 658	Continued From page 23 During an interview on 12/18/18 at 4:35 p.m., the Interim Director of Nursing (DON), stated if a resident has a physician order for continuous oxygen, portable oxygen should be utilized when the resident is transported and cannot use the oxygen concentrator. An undated Oxygen Administration Policy provided by the facility, identified to check the physician's order for liter flow and method of administration. The Policy also directed the staff to have a reserve oxygen tank available to provide continuity of care. 2. The Admission Record showed the resident #35 admitted to the facility on 2/20/13 with diagnoses of Multiple Sclerosis, lumbar and sacral spina bifida without hydrocephalus. The Minimum Data Set MDS) Assessment for resident #35, dated 10/10/19, identified a Brief Interview for Mental Status (BIMS) score of 1 indicating severe cognitive loss. The resident required extensive assistance with bed mobility, dressing and personal hygiene. The MDS listed the resident had pressure ulcers present and required pressure reducing devices for the chair, bed, turning, repositioning and pressure wound care. The Wound Dressing Order, dated 11/21/19, specified the following wound treatment orders: Wound Care Instructions: a. Clean the wound prior to each dressing change. You can clean the wound with saline, sterile water or soap and water. An appropriate cleanser is baby shampoo.	F 658		

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F 658	Continued From page 24 b. Pat wound dry. Ensure wound is dry prior to apply dressing. c. Moisten Gauze with Dakins daily. d. Cover with ABD pads, secure with tape. e. Change outer dressing more frequently as needed for drainage control. The Wound/Skin Healing Record, provided by the facility, showed a wound assessment for the left ischium (pelvic sit bone) with an onset date of 5/10/19. The Wound/Skin Healing Record, dated 12/17/19, at the time of observed wound care documented the left ischium as a stage 3 pressure wound. The December 2019 Treatment Administration Record (TAR), provided by the facility showed the treatment date of 12/4/2019 instructing nurses to flush the left ischial wound with Dakins solution, then dampen gauze with Dakins and loosely pack in wound. Cover with absorbent dressing every evening shift for stage 3 wound to left ischium. During observation on 12/18/19 at 2:45 p.m., Staff H, Registered Nurse (RN) set up wound care supplies on a clean barrier. Performed hand hygiene, gloved and placed a towel under the resident's left buttock. Staff H flushed the left ischial wound with Dakins (antiseptic) solution, without changing gloves, took a four inch by four inch piece of gauze and applied Dakins solution. Staff H then used a gloved finger to loosely pack the Dakins soaked piece of gauze into the left ischial wound. Staff H did not change gloves or perform hand hygiene. Staff H applied the clean absorbent dressing over the left ischial wound and secured the dressing with tape still wearing the dirty gloves.	F 658		

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F 658	Continued From page 25 During an interview on 12/23/19 at 10:45 a.m., Staff H, Nurse Manager, verified the physician order on 11/21/19 did not state to flush the left ischial wound with Dakins Solution or to pack the left ischial wound with Dakins soaked gauze. She stated since the resident came back from the wound clinic with the left ischial wound packed, she did not clarify the physician orders. Staff H reported she put the physician order in the TAR on 12/4/19 directing to dampen the gauze with Dakins Solution and loosely pack the wound with Dakins gauze so the nurses would know what to do for the treatment. During and interview on 12/23/19 at 11:10 a.m., the Interim Director of Nursing (DON), reviewed the wound order 11/21/19 directing the cleaning of the wound prior to each dressing change with saline, sterile water, soap and water or baby shampoo and 11/21/19 left ischium wound care. The Interim DON stated if the resident returned with the wound packed and the physician order did not order to pack the wound, the nurse would be expected to clarify the physician order for wound care. During an interview on 12/23/19 at 1:35 p.m., the Interim DON reported the facility did not have a policy regarding physician orders.	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		

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F 689	Continued From page 26 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation interview and record reviews the facility failed to secure chemicals away from residents. The facility reports a census of 74 resident. Findings included: 1. During an observation on 12/16/19 at 10:06 a.m., the unlocked housekeeping closet on the 100 hall contained: a. A 32 ounce (oz) bottle 1/2 full of P&G Proline Heavy Duty Spray Cleaner with the caution to keep out of reach of children on the label. b. A bottle of Spic and Span 32 oz 1/2 full with the caution keep out of reach of children. c. A bottle of Comet without a lid containing about 20 cubic centimeters (cc) in the bottle, directed keep out of reach of children. d. A bottle labeled CID with black marker Lysol was written on the bottle 1/4 full of yellow liquid. During an interview on 12/16/19 at 10:33 a.m., Staff L Certified Nurses Aide (CNA) reported the door to the housekeeping closet is expected to be locked. During an interview on 12/16/19 at 10:35 a.m., Staff L reported it is a self locking door if its shut tight. During an observation on 12/16/19 at 10:39 a.m., Resident #20 asked for more Cap San spray and held up a 1/2 full 7 ounce can of Cap San spray. Review of the can label identified the contents as flammable and to keep out of reach of children.	F 689		

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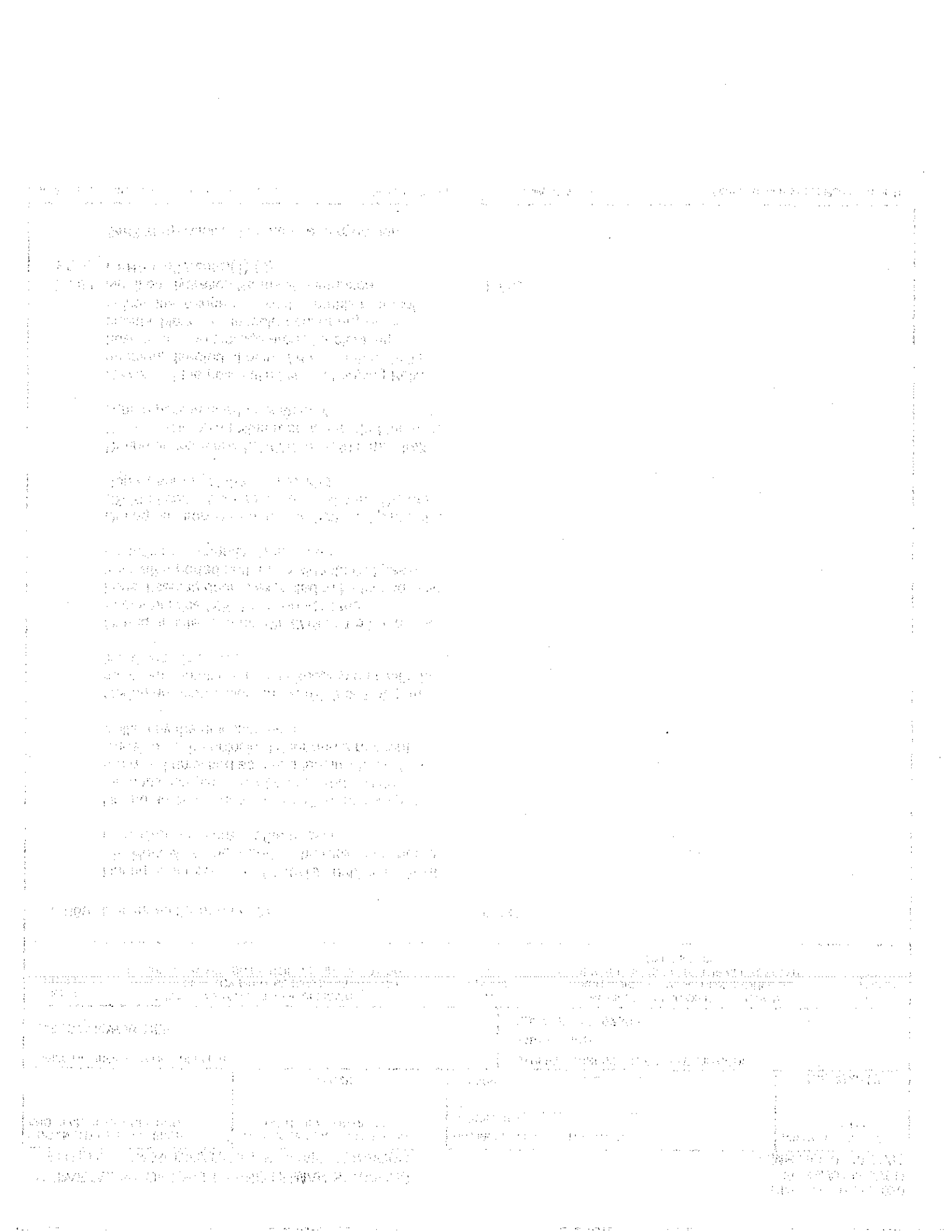
F 689	Continued From page 27 During an interview on 12/16/19 10:42 a.m., Staff PP, Housekeeping reported the resident is not to have Cap San spray at the bedside. During an observation on 12/16/19 at 1:48 p.m., the housekeeping closet on the 100 hall door remained unlocked as a resident in wheel chair wheeled by the unlocked door and a resident walked by the unlocked door. During an observation on 12/16/19 at 1:52 p.m., the room contained a housekeeping cart with the listed chemicals in it. During an interview on 12/16/19 at 1:54 p.m., the Social Service (SS) Staff reported the housekeeping door is expected to be locked. The SS staff reported both the residents that passed by earlier are cognitively impaired. During an interview on 12/16/19 at 1:56 p.m., the SS Staff came back to the door with the Dietary Supervisor to get the door locked. During an interview 12/16/19 at 1:58 p.m., Staff PP, Housekeeping Staff reported to shut the door tight, a person need to push on it. Review of the policy titled Housekeeping Policy undated, directed at point # 8 Residents shall not have access to storage areas for cleaning agents, bleaches, insecticides, or any other poisonous, dangerous, or flammable material.	F 689		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration.	F 692		



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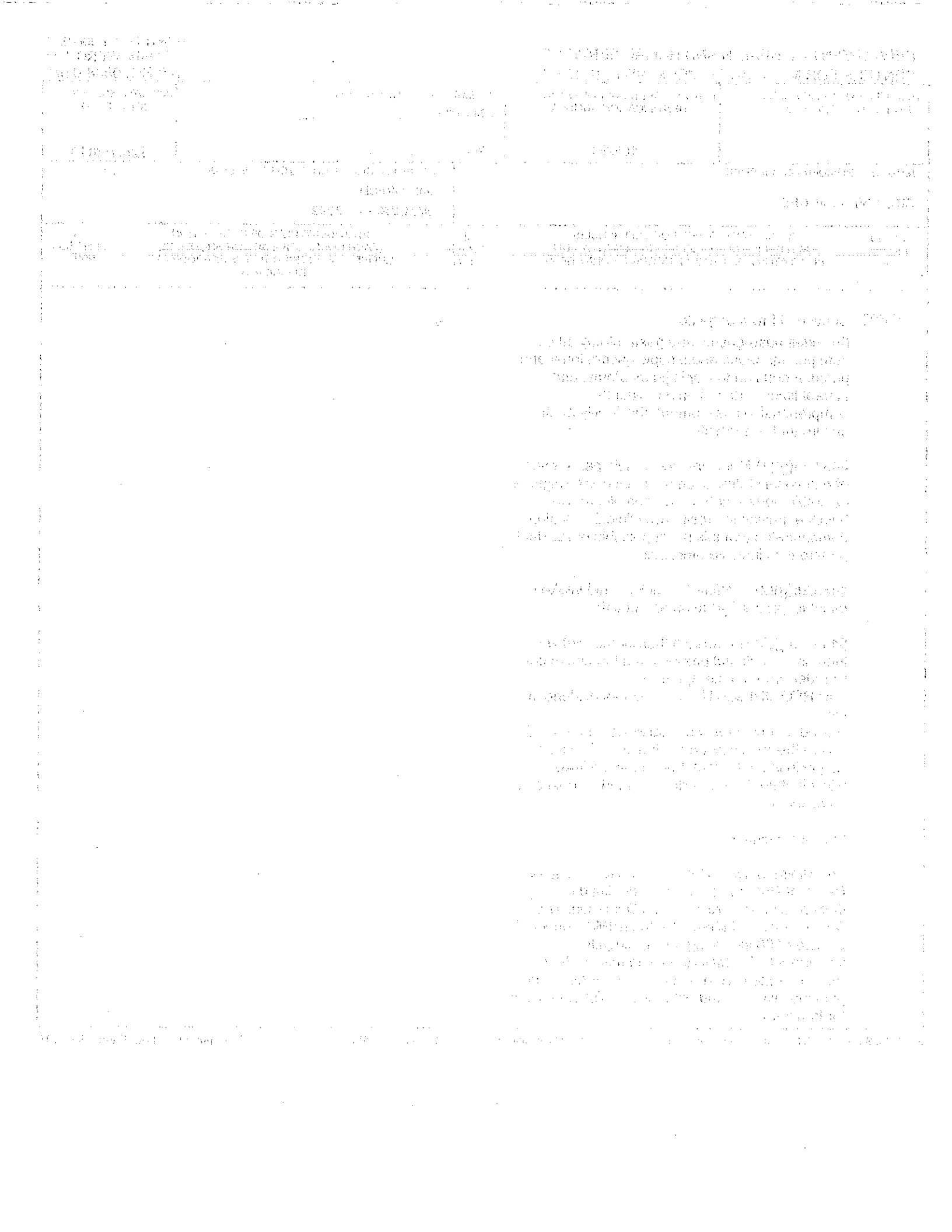
F 692	Continued From page 28 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the facility failed to identify a significant weight loss for 1 out of 1 residents reviewed (Resident #66). The facility reported a census of 74 resident. Findings included: The Minimum Data Set (MDS) assessment for Resident #66 dated 11/15/19, identified a diagnosis of Non-Alzheimer's Dementia. The Brief Interview of Mental Status (BIMS) reflected a score of 00 indicating severe cognitive impairment. The MDS identified the resident requiring extensive assist of one staff for eating, personal hygiene and extensive assist of two staff for transfers.	F 692		



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F 692	Continued From page 29 The Care Plan dated 3/5/16, directed staff to monitor weight per facility protocol, Physician's orders or as indicated. Notify family/Physician of significant weight changes in a timely manner, and the Registered Dietitian (RD) will assess as indicated/ordered. Review of the Quality Assurance Weekly Weight Loss Meeting list provided indicated Resident #66 with a significant weight loss on 10% over 180 days. The Physician's Progress Note dated 6/2/19, listed the resident weight as 143.5 pounds. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated 11/2019 and 12/2019, lacked direction for staff to administer the resident a Health Nutrition shake or a high calorie supplement. Review of the Weights and Vitals Summary for Resident #66 on 5/1/2019, listed weight of 142.8 lbs. The weight listed for Resident #66 on 11/4/2019, is 127.2 pounds which is a -10.92 % loss in 6 months. Review of the Dietitian's Recommendation sheets dated for September 2019, October 2019, November 2019 and December 2019 lacked identification of the significant weight loss for Resident #66. During an interview on 12/19/19 at 11:43 a.m., Staff QQ, Dietary Staff reported working at the facility for 2 years. Staff QQ continued to report Resident #66 always sat at an assisted table, and	F 692		

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F 692	Continued From page 30 is dependent on staff to eat, and also the resident leans more at the table and is sleepy. During an interview on 12/19/19 at 11:34 a.m., Staff J, Licensed Practical Nurse (LPN) reported the resident is not receiving any supplement for weight loss. During an interview on 12/19/19 at 12:01 p.m., the Director of Nursing (DON) pulled up the Weights and Vitals Summary report for Resident #66. The DON confirmed the resident had a significant weight loss in 180 days for December, November, October, September, and August. The DON acknowledged the weight report the Dietitian provided about the resident lacked documentation in regards to the significant weight loss. The DON reported unaware of Resident #66's significant weight loss. The facility provided an undated policy titled Procedure - Weight Meeting which directed the following: a. A monthly weight with noted significant changes (gains, losses and new admission) will be due to the Team each Monday as collected by the Dietary Manager. b. The Team (Director of Nursing, Nurse manager, Dietitian, Dietary Director and Administrator) will review the weights at the weekly Skin Meeting every Tuesday at 11:00 a.m.. c. The Dietitian will make recommendations based on the losses and gains.	F 692		
F 698 SS=D	Dialysis CFR(s): 483.25(l)	F 698		

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F 698	Continued From page 31 §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review the facility failed to perform standard assessment regarding vital signs checks before and after Dialysis treatments for 2 of 2 residents receiving Dialysis treatments. (Resident #5 and #69) The facility also failed to show weights completed for Resident #69. The facility identified a census of 74 residents. Findings include: 1. Resident # 5's Minimum Data Set (MDS) assessment dated 11/29/19 showed the resident with no memory deficits, required extensive staff assistance for daily cares, and indicated the resident received Dialysis treatment. The resident with diagnoses including diabetes, heart failure, and end stage renal failure. During an observation and an interview on 12/17/19 at 11:43 a.m., Resident # 5 shown the surveyor a central line in the right upper chest area. Resident #5 reported sometimes the Nursing Staff do vitals before going to Dialysis and coming back, but not always. The resident also reported the staff usually, but not always, check vitals after Dialysis but noted they always check the access port (central line). The Care Plan dated 10/31/19 identified the	F 698		

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F 698	Continued From page 32 resident with a medical need for Dialysis related to renal failure, and will go to the Dialysis Center on Monday, Wednesday and Friday. During an interview on 12/18/19 at 2:30 p.m., Staff J, Licensed Practical Nurse (LPN) reported standard procedure is to check resident's vitals before and after Dialysis treatments. She noted that is expected to be charted on the resident's Medication Administration Record (MAR's)/Treatment Administration Record (TAR's). During an phone interview on 12/19/19 at 8:30 a.m., Staff M, Registered Nurse (RN), reported standard procedure for Dialysis residents is to check their vital signs before and after the Dialysis treatment and to check their central port or fistula every day. The Medication Administration Record for the months of October 2019, and November 2019 showed staff were to check Dialysis port every shift for protocol. The following showed missing documentation by staff, indicating this protocol had not been followed: a. On 11 shifts in October not completed for this activity.. b On 8 shifts in November not completed for this activity. The Medication Administration Record for the months of October 2019, November 2019 , and December 2019 directed staff to check vital signs (blood pressure, pulse, temperature, and respirations) 2 times every Monday, Wednesday, and Friday for Dialysis protocol. The following showed missing documentation by staff, indicating this protocol had not been followed:	F 698		

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F 698	Continued From page 33 a. On 4 times in October 2019 the vital sign checks not completed. b. On 5 times in November 2019 the vital sign checks not completed. 2. Resident # 69's (closed record) MDS assessment dated 11/18/19 showed the resident with short and long term memory loss. The resident's diagnoses included diabetes, end stage renal disease, and received dialysis treatment. The Medication Administration Record for the month of December failed to show any documentation for Dialysis protocol regarding checking vitals signs and the checking of the central port or fistula. The Progress Notes (Nurse's Notes) from admission on 11/11/19 through 11/29/19 failed to show any vitals for before and after Dialysis treatments. During an interview on 12/19/19 at 8:30 a.m., Staff M, RN, reported the resident attended Dialysis on Tuesday, Thursday, and Saturday. Staff M reported standard protocol is to check vital signs before and after Dialysis treatment and check the fistula or central port every day. The Medication Administration Record for the month of December failed to show any documentation for the identified Dialysis protocol regarding weekly weights which may use the post Dialysis weight. The DON reported Dialysis protocol is to do vital signs before and after Dialysis and check their port and or fistula and would expect that to be	F 698		

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F 698	Continued From page 34 charted.	F 698		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review the facility failed to notify the Physician for 1 out of 4 resident's weight loss (Resident # 66). The facility reported a census of 74 residents. Findings included: The Minimum Data Set (MDS) assessment for Resident # 66 dated 11/15/19, identified a diagnosis of Non-Alzheimer's Dementia. The Brief Interview of Mental Status (BIMS) reflected a score of 00 indicating sever cognitive impairment. The MDS identified the resident	F 710		

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F 710	Continued From page 35 requiring extensive assist of 1 staff for eating, personal hygiene and extensive assist of 2 staff for transfers. The Care Plan dated 3/5/16, directed staff to monitor weight per facility protocol, Physician's orders or as indicated, and notify the family/Physician of significant weight changes in a timely manner. Review of the Quality Assurance weekly weight loss meeting list provided on 12/16/19, indicated Resident # 66 with a significant weight loss on 10% over 180 days. The Physician's Progress Note dated 6/2/19, listed the resident weight as 143.5 pounds. Review of the Weights and Vitals Summary for Resident # 66 for 5/1/2019, listed weight of 142.8 lbs. The weight listed for Resident # 66 on 11/04/2019, is 127.2 pounds which is a -10.92 % loss in 6 months. Review of the Dietitian's Recommendation sheet dated for September 2019, October 2019, November 2019 and December 2019 lacked identification of the significant weight loss for Resident # 66. Review of the Physician's Progress notes after 5/1/19, lack identifying or addressing the resident weight. During an interview on 12/19/19 at 12:01 p.m., the Director of Nursing (DON) pulled up Weights and Vitals Summary report for Resident # 66. The DON confirmed the resident with a significant weight loss in 180 days for December 2019,	F 710		

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F 710	Continued From page 36 November 2019, October 2019, September 2019, and August 2019. The DON confirmed nothing on the weight report the Dietitian provided addressed the resident's weight loss. The DON reported a lack of knowledge of Resident # 66's significant weight loss. The facility provided an undated policy titled Procedure - Weight Meeting Measurement directing the following: a. Monthly weight with significant changes (gains, losses and new admission) will be due to the team each Monday as collected by the Dietary Manager. b. The team (Director of Nursing, Nurse manager, Dietitian, Dietary Director and Administrator) will review the weights at the weekly Skin Meeting every Tuesday at 11 am. c. The Dietitian will make recommendations based on the losses and gains.	F 710		
F 741 SS=D	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:	F 741		

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F 741	Continued From page 37 §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: Based on document review and staff interviews the facility failed to provide required education to address the specific needs of residents residing in the licensed Chronic Confusion or Dementing Illness (CCDI) Unit. The facility identified a census of 74 residents. Finding include: Review of the Nursing Education Records for completion of the required 6 hours of Dementia Training identified the following concerns: Staff LL, Certified Nurse Aide (CNA), completed 5 hours Staff V, CNA, completed 5 hours Staff MM, CNA, completed 4.5 hours Staff W, Oral Medication Tech (OMT), completed 5 hours Staff NN, CNA, completed 2.5 hours Review of the nursing schedule from 11/20/19 to 12/17/19 showed the identified staff worked in the	F 741		

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F 741	Continued From page 38 CCDI unit during that time period. Review of an undated document titled "Resume of Program of Care", revealed in part " ... Policy - Staff trained to deal with the special needs of the resident of the Special Car Program will maintain the unit ... Initial training will be a minimum of 6 hours in length ...". The policy failed to identify the need for 6 hours of dementia specific training annually. During an interview on 12/19/19, 9:20 a.m., the Administrator confirmed the identified Nursing Staff appeared on the schedule in the past month and had not completed 6 hours of dementia specific training as required. During an interview on 12/23/19, at 9:45 a.m., the Administrative Assistant, reported she assigns the on-line training on a regular basis and the employees are responsible to log into the system and complete the training as assigned. She reported she looks at times to see if training is completed but does not routinely check to see that employees are completing the training as assigned.	F 741		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F 758		

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CRESTVIEW ACRES	1485 GRAND MARION, IA 52302

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F 758	Continued From page 39 (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 758		

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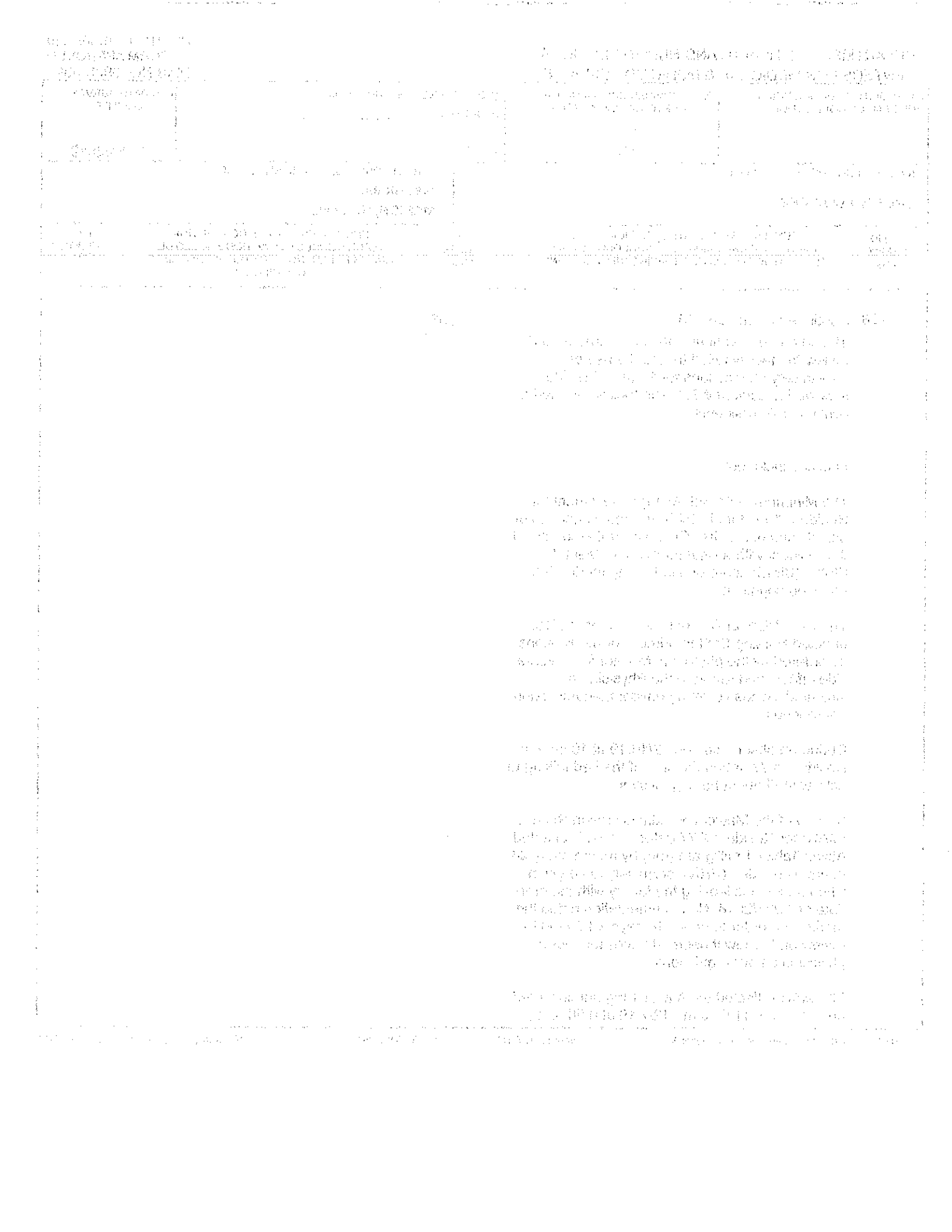
F 758	Continued From page 40 Based on observations, interviews, and record review the facility failed to limit the use of anti-anxiety medications for 1 out of 5 resident reviewed (Resident # 77). The facility reported a census of 74 residents. Findings included: The Minimum Data Set (MDS) assessment for Resident # 77 dated 11/22/19 listed diagnoses of anxiety and dementia. The MDS further identified the resident with a Brief Interview of Mental Status (BIMS) score of 8 indicating moderately impaired cognition. The Care Plan for Resident # 77 dated 8/9/15, directed Nursing Staff to administer medications as ordered by the physician. Monitor for adverse side effects and report to the Physician as indicated. Assess calming environment/diversion approaches. During an observation on 12/16/19 at 10:54 a.m., Resident # 77 sat on the side of the bed talking to activity staff about hurting all over. Review of the Medication Administration Record (MAR) for Resident # 77 dated 12/2019, directed Ativan Tablet 1 milligram (mg) by mouth every 24 hours as needed (PRN) for Anxiety to be given when resident is leaving the facility with the order date of 11/21/2018. No documentation noted the medication order to be for 14 days with need to review and renew if deemed necessary per the physician as per regulations. The MAR reflected the Ativan 1 mg administered on 12/4/19 at 11:51 p.m., 12/7/19 at 6:56 a.m.,	F 758		



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F 758	Continued From page 41 12/8/19 at 7:22 a.m., and 12/16/19 at 7: 28 a.m. Review of the Health Status Note dated 12/16/2019 at 11:20 a.m., reflected resident is screaming and crying. The nurse reported has already given resident a PRN Ativan. The note lacked documentation of interventions prior to administration of the Ativan. During an interview on 12/23/19 at 2:48 p.m., the Interim Director of Nursing (DON) reported expecting the nurses to follow the Physician's order and to call the Physician if the order needed changed. The DON reported a lack of knowledge of the 14 day rule for anxiety medication.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff interview the facility failed to properly prime the insulin flex pens prior to insulin administration for 2 of 2 residents resulting in an 10% medication error rate. (Resident #6 and #30) The facility identified a census of 74 residents. Findings include: 1. The Admission Record for Resident #6 identified the resident admitted to the facility on	F 759		

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F 759	Continued From page 42 2/14/2019 with a diagnosis of Type Two Diabetes. The Order Review Report, signed by the physician on 12/11/19, identified the resident with the following physician orders: a. Lantus Solution 30 units subcutaneously one time a day. b. Novolog Solution 100 Unit per milliliter, inject 10 units subcutaneously before meals c. Novolog Flex Pen Solution Pen Injection 100 units per milliliter. Inject per sliding scale: 150 - 199 = 1 unit 200 - 249 = 2 units 250 - 299 = 3 units 300 - 349 = 4 units Greater then 350 give 5 units subcutaneously before meals. During an observation on 12/17/19 at 8:37 a.m., Staff H, Registered Nurse (RN), prepared the Lantus Insulin Flex Pen for insulin administration by applying the needle and dialing the Lantus insulin pen to 30 units. Staff H failed to prime the insulin pen with two units of insulin during preparation. Staff H then prepared the Novolog Flex Pen for the scheduled insulin dose and for a blood sugar of 250 by applying the needle and setting the Novolog pen to 13 units. Staff H failed to prime the insulin pen with two units of insulin during preparation. 2. The Admission Record for Resident #30 showed the resident admitted to the facility on 12/28/18 with a diagnosis of Type Two Diabetes. The Order Review Report, signed by the Physician on 12/10/19, listed the following orders: a. Levemir Solution, inject 68 units	F 759		

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F 759	Continued From page 43 subcutaneously two times a day b. Novolog Solution, inject as per sliding scale: 240 - 279 = 2 units 280 - 309 = 3 units 310 - 339 = 4 units 340 - 369 = 5 units 370 - 389 = 6 units 390 - 409 = 7 units Subcutaneously three times a day for Diabetes Mellitus. During an observation on 12/17/19 at 7:55 a.m., Staff H, Registered Nurse (RN), prepared the Levemir Solution Insulin Pen by applying the needle and setting the dial to 68 units. Staff H failed to prime the Levemir Insulin Pen with 2 units of insulin during preparation. Staff H then prepared the Novolog Solution Insulin Pen by applying the needle and setting the dial to 20 units. Staff H failed to prime the Novolog Insulin Pen with 2 units of insulin during preparation. During an interview on 12/18/19 at 4:20 p.m., the Nurse Consultant identified the nurses should prime the insulin pen with two units of insulin during preparation for insulin administration. She reported the facility did not have a policy regarding the administration of insulin per flex pen but would expect the nurses to follow the current standard of practice which is to prime the pen with 2 units of insulin as part of medication administration. During an interview on 12/18/19 at 4:35 p.m., the Interim Director of Nursing (DON) reported the nurses should follow the standard of practice to prime the insulin pen with two units of insulin during insulin preparation.	F 759		

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F 759	Continued From page 44 During an interview on 12/18/19 at 4:45 p.m., the Nurse Consultant provided a document entitled, "How to use a FlexPen," from Novo Nordisk and reported the the nurses would be required to follow the proper administration for using a insulin flex pen. The quick guide instructions included: 1. Check the pen. 2. Attach a new needle 3. Check the insulin flow: a. Turn the dose selector to select two units. b Press the push-button all the way in. c. The dose selector should return to zero and a drop of insulin should appear at the needle tip. 4. Select your dose a. Check that the dose selector is set to zero. b. Turn the dose selector to select the number of units needed for injection. 5. Inject the dose 6. Remove the needle The undated Medication Administration Policy, provided by the facility, did not address the use of insulin pens.	F 759		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other	F 801		

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F 801	Continued From page 45 clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1	F 801		

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F 801	Continued From page 46 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on document review and staff interviews, the facility failed to employ a qualified person to serve as the Director of Food and Nutrition Services in the absence of a full-time Dietitian and ensure sufficient scheduled consultations from a qualified Dietitian to provide adequate oversight and support to the department. The facility identified a census of 74 residents. Findings include: During an interview on 12/16/19, at 9:35 a.m., the Dietary Manager reported been employed in the position since September of 2019 and not a Certified Dietary Manager (CDM). He confirmed the facility's Dietitian is not employed full-time and reported he is enrolled in online Certified Dietary Manager (CDM) course.	F 801		

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F 801	Continued From page 47 During an interview on 12/17/19, at 7:40 a.m., the Dietary Manager reported he had completed a Certified Food Protection Program (ServSafe) awhile back but unsure if it remained current and will try to find his certificate. During an interview on 12/19/19, at 8:30 a.m., the Administrator reported the Dietary Manager discovered his food safety certification had expired and is looking at options to re-test. During an interview on 12/17/19, at 9:20 a.m., the Dietary Manager reported the Consultant Dietitian has not had any involvement in the kitchen since he's been employed at the facility. He reported she has not completed any education with him related to facility menus, spreadsheets, meal service, etc. and does not come in and do any checks of environment, food preparation or meal service During an interview on 12/17/19, at 10:40 a.m., the Consultant Dietitian reported she spends approximately 8-12 hours per week in the facility and has been consulting at the facility for about 1 year. She reported her activities at the facility are primarily clinical except for an occasional kitchen environment walk-through. The Consultant Dietitian acknowledged she's not sure she has completed a kitchen environment walk through since the current Dietary Manager became employed in November and confirmed she has not conducted any training with him or the Dietary Staff. During an interview on 12/19/19, at 8:50 a.m., the Dietary Manager, confirmed the Consultant Dietitian has not gone over therapeutic diets,	F 801		

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F 801	Continued From page 48 menus, binders, etc as identified in her consultant recommendation report from 10/1/19. He acknowledged he did not have a working knowledge of menus and spreadsheets related to a work history in restaurant foodservice. The Dietary Manager reported he has not actually started the CDM course yet, as he is waiting for the dietitian to fill out some paperwork associated with the enrollment, since she will have to supervise his work on the course. During an interview on 12/23/19, at 10:10 a.m., the Administrator confirmed the Dietary Manager's enrollment in the CDM program is not complete because they are waiting on something the Dietitian needs to sign and turn in with the enrollment application. During an interview on 12/23/19, 4:30 p.m. the Administrator acknowledged the facility's Consultant Dietitian failed to provide adequate consultation with the current Dietary Manager to assist in carrying out the functions of the department. During an interview on 12/23/19, on 4:30 p.m. the Administrator acknowledged she didn't believe their current Consultant Dietitian had been providing the Dietary Manager adequate support. She acknowledged the Consultant Dietitian confirmed she has had minimal involvement with the current manager. The Administrator provided documentation from their corporate office which identified the Dietary Manager's employment date as 9/16/19. Review of documents titled "Dietitian Recommendations", from August 2019 to	F 801		

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F 801	Continued From page 49 December 2019 revealed the document dated 10/1/19 revealed the Consultant Dietitian commented on foodservice related activities/concerns and documented in part "... Meet to go over: diets/menus, binders ... " The Consultant Dietitian documented no other activities related to the foodservice department in that time period. Review of a document titled "Consulting Dietitian Agreement" dated 10/29/18 identified the agreed upon services included in part "... observe meal preparation and recommend changes as needed, develop and present in-service education ... assist in developing managerial and supervisory skills of facility's food service department supervisor through on the job education ..." The 2013 Food Code, published by the Food and Drug Administration and considered a standard of practice for the food service industry, requires an employee with supervisory and management responsibility and the authority to direct and control food preparation and service must be a certified food protection manager.	F 801		
F 803 SS=F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed;	F 803		

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F 803	Continued From page 50 §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, document review, menu review and staff interviews the facility failed to follow the planned menu for 2 of 3 meals observed . The facility identified a census of 74 residents. Findings include: Review of document titled "Diet Type Report", dated 12/16/19, revealed the facility identified 10 residents on a pureed diet and 8 residents on a mechanical soft diet. 1. Review of the facility's Week 2 menu identified the following as part of the planned menu for the noon meal on 12/16/19: Regular diet - 6 ounce (approximately 3/4 cup) Italian pasta bake, 8 ounce spoodle (food portioning device approximately 1 cup) tossed salad/dressing Mechanical soft - 6 ounce (oz) pasta bake, 8 oz.	F 803		

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F 803	Continued From page 51 spoodle shredded lettuce/dressing Pureed - 1 serving pureed Italian past bake, 1 serving pureed tossed salad/dressing Observation on 12/16/19, at 10:36 a.m., revealed Staff HH, Cook, assigned to prepare the pureed food for the noon meal. She proceeded to fill the Ninja blender with an unmeasured amount of chopped lettuce, shredded cheese, 3 - #24 scoops of cottage cheese and a small amount of whole milk. She reported she does not measure anything; just fills the blender up so there is nice amount. She processed the mixture until smooth, scraped the contents into a pan, without measurement of volume, and stored in refrigerator for lunch. Observation on 12/16/19, at 11:30 a.m., revealed Staff HH prepared the pureed Italian sausage bake. She filled the Ninja blender nearly full with an unmeasured amount of pasta bake. She reported she needed to leave room for some milk, and added an unmeasured amount of whole milk and 3 bread slices. She processed the mixture until smooth, scraped the contents into a pan, without measurement of volume, and placed it on the steamtable for service Observation of the noon meal service on 12/16/19, from 11:52 a.m. to 1:00 p.m., revealed Staff II, Cook, assigned to serve the noon meal. She reported Staff HH put the serving scoops in the various items to be served and used a #10 scoop (approximately 3/8 cup) for the Italian pasta bake, instead of the identified 6 oz, #16 scoop pureed tossed salad (approximately 1/4 cup), #12 scoop (approximately 1/3 cup) for the pureed pasta bake. The tossed salad available for service consisted of chopped salad with	F 803		

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F 803	Continued From page 52 cucumber slices and chopped tomatoes but no tossed salad made with shredded lettuce, as identified for the mechanical soft diet. During the observation, 6 of 8 residents on a mechanical soft diet received the chopped tossed salad, rather than the identified shredded lettuce. All residents served on a regular and mechanical soft diet received a #10 scoop of pasta bake, rather than the identified 6 oz. and 9 of 10 residents on a pureed diet received portions Staff II determined without using a specific guideline. During an interview on 12/17/19, 9:10 a.m. Staff HH displayed the menu available in the kitchen for staff to follow, which identified a menu titled "Week at a Glance". This menu did not identify the various therapeutic diets and the portion sizes for each item. She reported she does not really know what the portion sizes are supposed to be; bases what she does on what she learned from another cook when new. Staff HH reported she selects a portioning device that seems like a reasonable serving. She reported she does the same thing for pureed food as she never received any training on the pureed process either. She thought they were supposed to use the posted pureed diet portion chart but had never been trained to use it. The Dietary Manager reported he has not done any training with staff on the pureed process or serving sizes and the dietitian has not either. During an interview on 12/17/19, at 10:40 a.m., the Consultant Dietitian reported she spends approximately 8-12 hours per week in the facility and the majority of her time is spent on the clinical side. She confirmed she had not completed any training with the Dietary Manager or dietary staff on the pureed process or menu	F 803		

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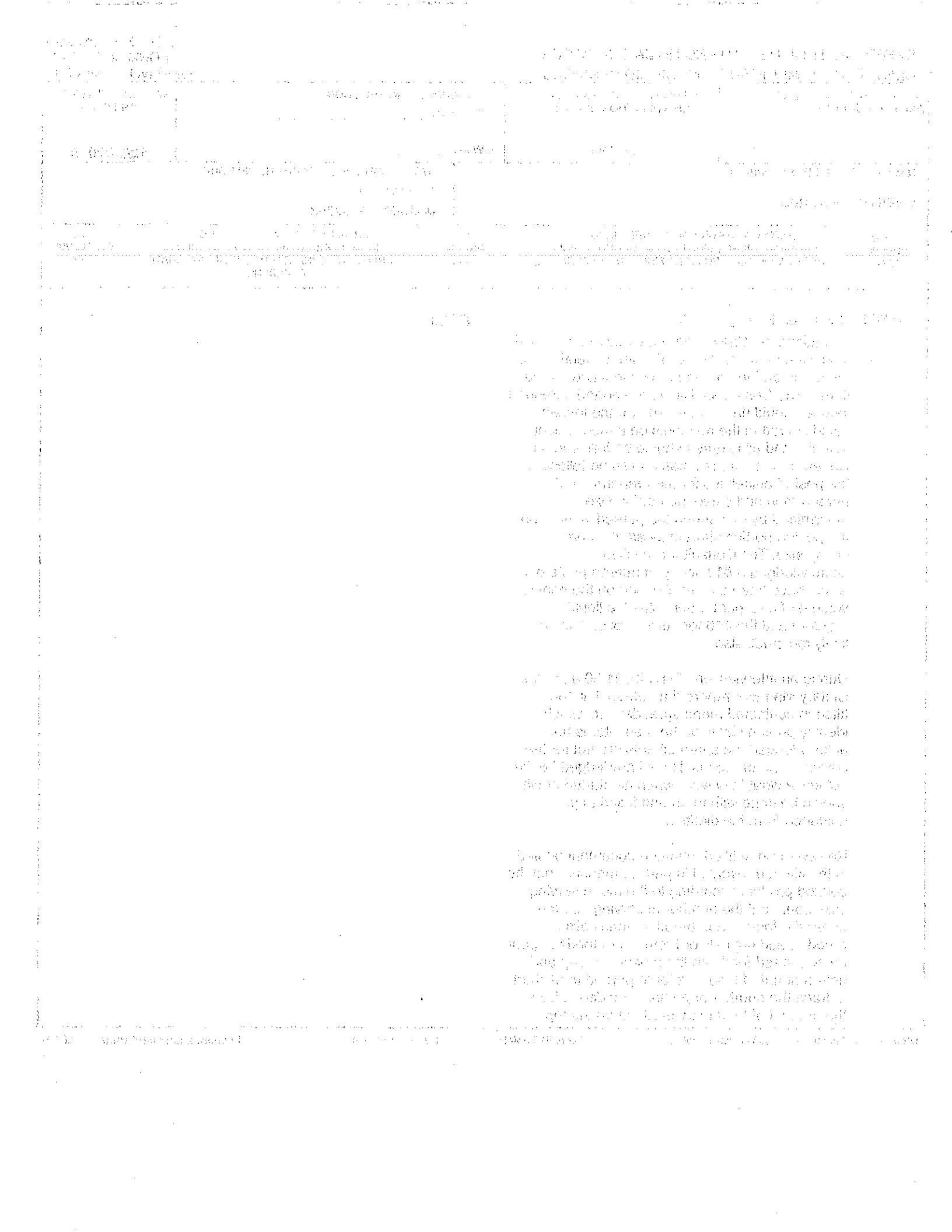
F 803	Continued From page 53 spreadsheets. She confirmed dietary staff should follow the menu and serve the items identified on the menu and the portion sizes identified for the items. The Consultant Dietitian reported shredded lettuce should have been used for the tossed salad served to the residents on a mechanical soft diet and all textures should be followed as written. She confirmed staff should be following the posted guidelines for the preparation of pureed food and serve the portion size determined by measuring the pureed volume and the posted portion chart to locate the correct scoop size. The Consultant Dietitian acknowledged a #12 scoop of pureed pasta bake would have been too small based on the original volume of 6 oz per person, plus the liquid required and the #16 for pureed tossed salad likely too small also. During an interview on 12/17/19, 11:50 a.m., the Dietary Manager reported a notebook in the kitchen contained menu spreadsheets which identify portion sizes for the menu items but acknowledged the spreadsheets are not for the current cycle of menus. He acknowledged he did not know what they were when he started or what should be done with them and failed to get guidance from the dietitian. Review of an untitled, undated document posted in the kitchen revealed in part "... measure out the cooked product according to the menu serving size, count out the number of serving needed ... puree the food ... add bread if menu calls for bread ... add hot milk or broth to hot foods ... pour entire pureed food into the measuring cup and note amount of food ... refer to pureed food chart ... trace the number of portions needed ... trace the amount of food measured out on the top ...	F 803		



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F 803	Continued From page 54 when the two meet, this is the utensil used for correct portions. 2. Review of the facility's Week 2 menu identified the following as part of the planned menu for the noon meal on 12/17/19: Regular diet - #8 (approximately 1/2 cup) mashed potatoes, 4 oz spoodle (approximately 1/2 cup) peas Mechanical soft - #8 mashed potatoes, 4 oz spoodle wax beans Observation on 12/17/19, at 12:30 p.m., revealed Staff II assigned to serve the noon meal and in the process of serving the main dining room. She used a #12 scoop (approximately 1/3 cup) to serve the mashed potatoes and a 3 oz spoodle to serve the peas (approximately 1/3 cup) instead of the identified #8 scoop and 4 oz. spoodle. Staff II had no wax beans available for service to the residents on a mechanical soft diet, as identified on the planned menu. During an interview at the time, Staff II reported all residents received peas for the vegetable today. During an interview on 12/19/19, at 8:50 a.m., the Dietary Manager confirmed the Dietitian did not meet with him to go over diets, menus or recipe binders as she identified on her consultant report dated 10/1/19 and he acknowledged he did not have a working knowledge of menus/spreadsheets and their importance so he has not done education with the dietary staff on following them.	F 803		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)	F 804		

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F 804	Continued From page 55 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident/ group interviews, record and policy review the facility failed to address resident's choices and preferences to have condiments served with their room trays for all meals. The facility also failed to serve food at a palatable temperature for 2 of 2 meals served and observed. The facility identified a census of 74 residents. Findings include: 1. During an observation and interview on 12/16/19 at 10:15 a.m., Resident # 38 reported not wanting to eat breakfast as the full food tray sat next to the bed with no condiments present. Observation at noon in Resident #38's room showed the requested mashed potatoes present on the room tray, with no condiments present. During an observation and interview on 12/16/19 at 12:14 p.m., Resident # 39 reported the food cold most of the time, as the room tray sat in the room with no condiments present. During an observation on 12/17/19 at 9:30 a.m., revealed a food tray present with no condiments in Resident # 39's room. Observation at 12:40 p.m. revealed a room tray in the room with no	F 804		

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F 804	Continued From page 56 condiments. The resident reported not eating it because of a swallowing problem. The resident remarked asked for chicken noodle soup yesterday and the kitchen said they didn't have any available. The resident then asked for broth and or ice cream and the Dietary Staff reported neither item available. On 12/17/19 at 1:00 p.m. the Dietary Manager reported the kitchen did not have chicken noodle soup, but could make some both and did have some ice cream and would deliver that to Resident #39. Observation on 12/18/19 at 8:25 a.m., noted a food tray in Resident #38's room sat with no condiments present. During a group interview on 12/16/19 at 1:00 p.m., conducted with 5 interviewable residents deemed by the facility. 5 of 5 residents reported condiments never come on the room food trays, and they have expressed those concerns, and nothing has happened. The Resident Council Meeting minutes for 10/2019 included the following: a. No snacks, staff had to go to the kitchen for snacks, cold and late lunches- which Dietary said they were working on this concern and the Administrator noted this would take time to get things straightened out. b. Dietary reported to start delivering room trays with condiments. The Resident Council Meeting minutes for 11/2019 included the following: a. no snacks, staff had to go to the kitchen for snacks, cold and late lunches- dietary are trying	F 804		

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F 804	Continued From page 57 new things. The Administrator noted this would take time to get things straightened out. b. Dietary reported to start delivering room trays with condiments. During an interview on 12/19/19 at 7:12 a.m., the Dietary Supervisor reported they do not send out condiments on room trays. The residents would have to ask for any sugar, salt, creamers, and pepper. Then they wait for those to come with their request. The food may get cold if they wait very long, but they get the residents' requests out as soon as asked from the kitchen. The Dietary Supervisor commented he can only order so much of the condiments and chicken noodle soup according to the budget he must follow. He remarked if the food items/supplies run out, they have to wait till the next order for delivery for those items. The Dietary Supervisor remarked he sends out the bedtime snacks before kitchen staff leave around 7 or 7:30 p.m. and it is up to the Nursing Staff to deliver the snacks. An interview on 12/19/19 at 1:20 p.m. the (acting) Director of Nursing (DON), agreed it would be nice to have condiments on the residents' trays. A paper posting in the dining room area by the kitchen shown the Meal Times which included the statement that snacks will be passed between 7:00 p.m. and 7:30 p.m. The posting also stated additional snacks will be available upon request, in addition to being provided at the Welcome Center. II. Observation during the breakfast meal on 12/17/19, beginning at 8:17 a.m., revealed dietary staff had begun dishing food for the 100 hall room trays. Staff HH, cook, served the hot food with the	F 804		

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F 804	Continued From page 58 scrambled eggs and boiled eggs on the steamtable and the oatmeal pan sat on the stove, without the burner turned on. Staff HH began dishing the 300/400 hall room at 8:30 a.m. and dished a test tray at 8:39 a.m and Staff RR, dietary aide, left the kitchen with the cart to begin delivery. The Dietary manager measured the food temperatures immediately after delivery of the last tray at 8:44 a.m. as follows: scrambled eggs - 118.1 degrees, oatmeal - 112.8, boiled egg - 101.4 degrees. The Dietary Manager acknowledged the oatmeal and boiled egg tasted "cold" and the scrambled eggs tasted slightly warm but could be hotter. He reported he had received resident complaints about the hot food being cold so he changed the process for passing room trays in October and started having dietary staff pass the room trays. Observation on 12/17/19, at 9:00 a.m., revealed Staff HH completed breakfast meal service and upon request, measured the end temperatures of the problem items on the test tray. The scrambled eggs measured 158, boiled eggs measured 109.6 degrees and the oatmeal measured 101.4 degrees. She reported she documented a temperature of 160.2 degrees for the scrambled eggs pre-service but acknowledged she did not measure a temperature of the boiled eggs or oatmeal pre-service. Observation on 12/17/19, at 1:00 p.m., revealed dietary staff had begun dishing food for the 300/400 hall room trays. Requested a test tray to be added to the cart, which they dished at 1:15 p.m. The Administrator accompanied the room tray cart and confirmed the temperatures of the test tray measured at 1:24 p.m.. as follows: peas - 112.6 degrees, potatoes - 122 degrees and the	F 804		

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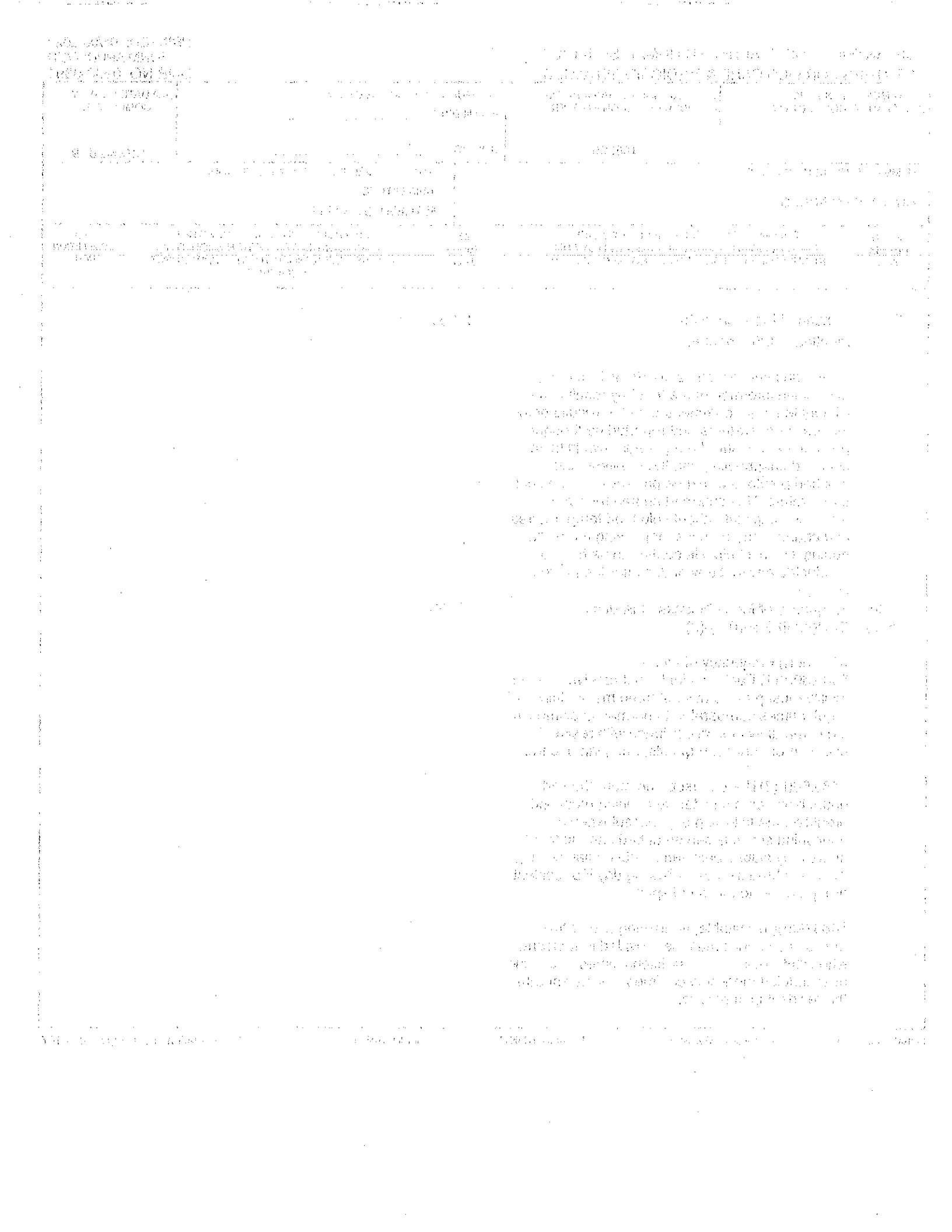
F 804	Continued From page 59 meatloaf - 126.8 degrees. During an interview on 12/16/19, at 1:35 p.m., after being informed of the test tray results, the Dietary Manager commented on the results of the test tray temperatures and reported he thought peas at the measured temperature would taste cold and unappealing and the meatloaf and mashed potatoes would be preferable at a higher temperature. He confirmed he had received resident complaints about cold food temperatures and changed the process for passing room trays hoping it would help. He confirmed he has not conducted any test tray audits after the process change.	F 804		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.	F 809		



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F 809	Continued From page 60 This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident and Group Interviews, and record review the facility failed to offer bedtime snacks. The facility identified a census of 74 residents. Findings include: 1. During a Group Interview on 12/16/19 at 1:00 p.m. conducted with 5 interviewable residents deemed by the facility; 5 of the 5 residents reported not getting their bedtime snacks and all of them remarked they would like to receive a snack most nights. Resident #13 reported being woke to receive the bedtime snack would be okay and also remarked has asked for a snack and it just doesn't come. A paper posting in the dining room area by the kitchen shown the Meal Times which included the statement that snacks will be passed between 7:00 p.m. and 7:30 p.m. The posting also stated additional snacks will be available upon request, in addition to being provided at the Welcome Center. Observation on 12/16/19 at 7:46 p.m. revealed no evidence of snacks at the north end of the facility. The South end contained a bucket with snacks. Later, with the Administrator present, kitchen staff brought a snack bin to the north station. Neither of the snack bins had milk or peanut butter sandwiches. During an interview on 12/16/19 at 8:00 p.m., Staff M, Registered Nurse (RN) reported they have snack bins at both nurses stations and they usually ask residents still up around 8:00 if they	F 809		

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F 809	Continued From page 61 want something. She also remarked some residents that are already in bed may take one later if they wake up. During an interview on 2/16/19 at 8:09 p.m., Staff N, Evening Cook, reported she generally takes the snack bins to both Nurses Stations around 8:00 and nursing will pass them out. During an interview on 12/16/19 at 2:00 p.m., the Dietary Supervisor reported Dietary takes a bucket of a variety of prepackaged snacks to both Nurses Stations at about 7:30. In addition they take out peanut butter sandwiches and milk. The nursing staff are to bring the buckets back when they need restocked. During an interview on 12/19/19 at 3:30 p.m., Staff E, Certified Nursing Aide (CNA) has been employed just 3 weeks, reported they pass the snacks out between 7 and 8 p.m. She didn't know if she should wake up residents or not, but knew the residents with diabetes should have a snack. If she gets behind she asks others to help out. During an interview on 12/19/19 at 7:12 a.m., with the Dietary Supervisor reported sending out the bedtime snacks before kitchen staff leave around 7 or 7:30 p.m. and it is up to the nursing staff to deliver the snacks. During an interview on 12/19/19 at 1:20 p.m., the Director of Nursing (DON), reported nursing staff responsible for passing bed time snacks. Residents who want to be woken up, should be woken up. Residents with diabetes should be woken up for bedtime snacks and any other residents who want to be woke up. The snacks should be more specific to residents choices and	F 809		

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F 809	Continued From page 62 maybe care planned.	F 809		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, document review, policy review and staff interview the facility staff failed to maintain the kitchen in a clean and sanitary manner, maintain food contact surfaces in a clean condition, ensure the dishmachine met manufacturer and regulatory requirements and serve food under sanitary conditions to reduce the risk of contamination to food and food-borne illness. The facility identified a census of 74 residents. Findings include:	F 812		

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F 812	Continued From page 63 I. Observation of the kitchen, during the initial environment tour, on 12/16/19, from 9:30 a.m to 10:45 a.m, revealed the following concerns: 1. The hand sink had a soiled rag lying in it and the sink appeared soiled with splashes and splatters that appeared dark brown, light brown and reddish in color. 2. The wall, pipes and hoses behind the ice machine had a build up of soil and dust and the floor behind and around the ice machine showed a build up grime with bits of paper and scattered debris. 3. The lower portion of the wall, behind the dish machine and dish machine tables, and the horizontal drain pipes under the dish machine had a buildup of food debris and the soil. The portion of the walls, above the soiled end dish machine table showed multiple food and beverage splatters along the entire length extending upward approximately 3 feet. The east kitchen door by the dishmachine, extending upward about halfway, and the wall to the left, had a heavy build up of dried food and beverage splatters. The door had rusty hinges with areas of rust showing on the frame. During an interview at the time, the Dietary Manager reported this area had been on a monthly cleaning schedule but he revamped the cleaning schedule in November and changed to it to weekly. He acknowledged the soiled condition of the door. 4. The top of the dish machine had a large amount of lime build up and food crumbs scattered across the entire top of the machine.	F 812		

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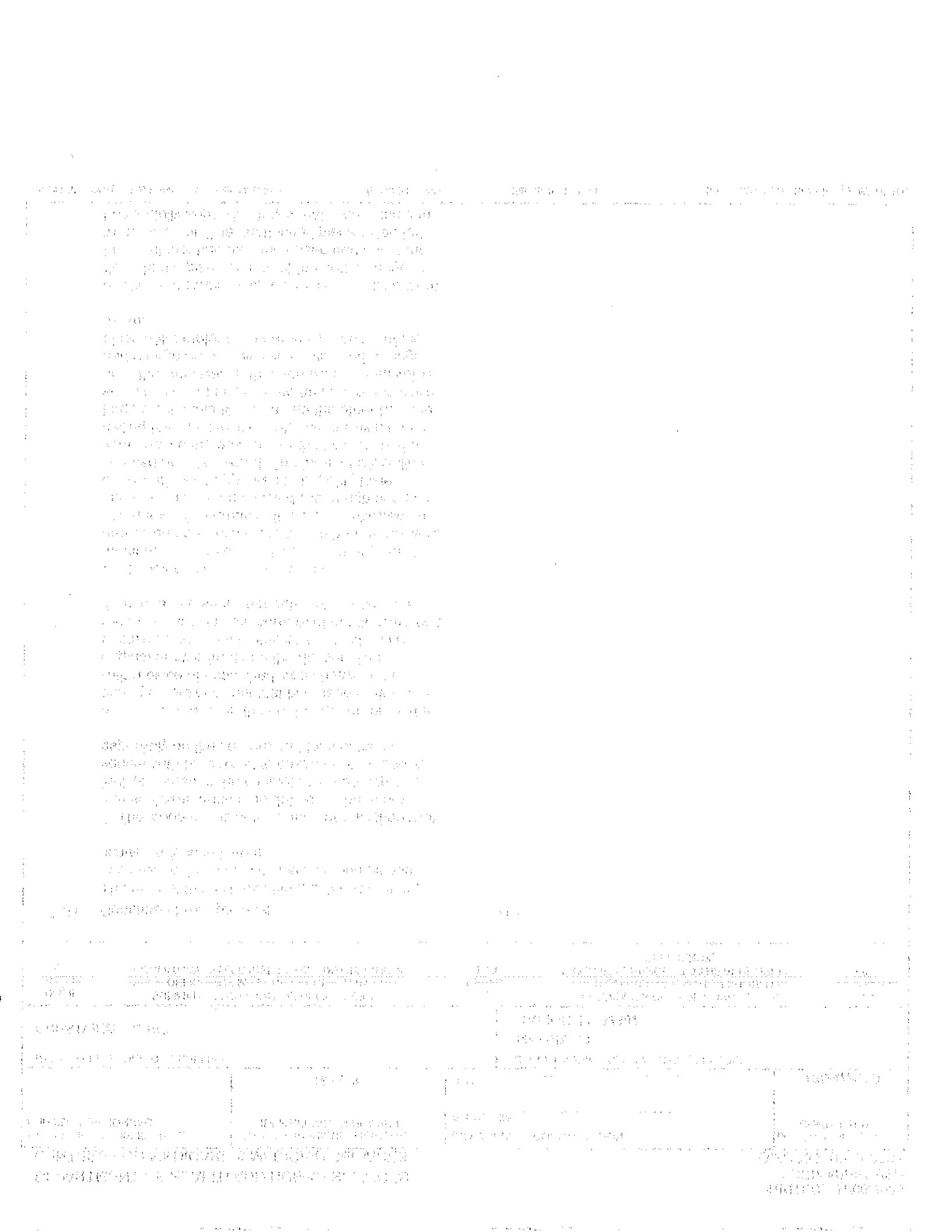
F 812	Continued From page 64 The front of the dish machine, extending up to, and around the chemical squeeze pumps had scattered food splatters. 5. The wooden cabinets on the north kitchen wall had scattered dried food debris on the doors. Multiple areas of the cabinets showed degraded veneer with bare wood exposed in some areas, especially on the corners and tops of the doors. 6. A utility drawer, in the northwest corner, had a damaged drawer front that had been reattached with a piece of unfinished wood between the original drawer front and the drawer. The exposed areas of the unfinished wood had a rough surface and the corners of the drawer been damaged and showed rough, unfinished edges. 7. The kitchen ceiling consisted of medium-textured ceiling tiles, with many small groves and crevices which would harbor moisture and grime. Two areas of the sealing showed an attempt at repair and sealed with rough beads of caulk and, what appeared to be, old plaster, cracked and discolored. The large black ceiling vent, toward the east end of the kitchen, had 3 ceiling tiles next to the vent, one of which had a large black mold-like area and the other two had small black mold-like areas. An area of the ceiling near the west wall, with a sprinkler system valve, had a large area of discolored tile, and a rough plaster-like material smeared over some of the seams. 8. The south wall soffit, above the chemical room door, had a piece of trim at the bottom edge of the soffit that had become unsecured and hung from the soffit. The unattached piece extended horizontally approximately 5 feet. The loose trim	F 812		



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F 812	Continued From page 65 created a gap at at the edge of the soffit and the material covering the bottom of the soffit , sagged approximately 2 inches at the lowest and extended vertically past the length of the loose trim. 9. The walk-in refrigerator floor had debris scattered across the floor, including pieces of paper and cardboard remnants, food crumbs, a yogurt cup and margarine pats. In the back left corner, a pool of light brown liquid covered an area approximately 12" X 6" . The walk-in refrigerator lacked an internal and external thermometer. The Dietary Manager reported there should be a thermometer inside the unit and would try to find one. He reported the dietary staff are supposed to check temperature in the AM and PM to ensure it is maintained at the required temperature. He acknowledged he currently does not require staff to log the temperatures so unable to produce records of routine temperature checks and maintenance of the required minimum cold holding temperature of 41 degrees or below. During an interview at the time, Staff GG, dietary aide, reported the thermometer had been missing for at least a week. Additional concerns identified in the walk-in refrigerator included: - On a tray, just inside the door, 2 peeled boiled eggs laid uncovered on a tray. During an interview at the time, Staff GG acknowledged she did not know why the boiled eggs had not been stored in labeled/dated container and discarded them. - Staff GG identified an area of the refrigerator had been designated to store a residents personal food items brought in for her. Observation of the items revealed the following: a small container of moldy watermelon chunks, with	F 812		

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F 812	Continued From page 66 an illegible "use by" date, 2 - 32 ounce (oz) containers of partially used vanilla yogurt with "best by" dates of 10/7/19 and 9/24/19, a small undated container labeled tapioca. Staff GG reported she had no idea how long the tapioca had been there and would discard it, along with the other items. - An unlabeled, undated gallon ziplock bag held 8 peeled, boiled eggs. There was a small amount of discolored yellowish liquid in the bag; opened the bag and noted an unpleasant order. Staff GG acknowledged she did not know how long they had been there and discarded the bag. - 1 slice pizza, wrapped in foil with no label or date. Staff GG reported the pizza slice probably belonged to staff and discarded it. - A 5# package of shredded Swiss cheese, dated 11/14/19, had not been sealed and left open to air. - A 5# package of shredded mozzarella. cheese, dated 11/21/19, had not been sealed and left open to air. - A 5# package of sliced white American cheese, with the cellophane package torn open and cheese slices lying on the cellophane with no protection from contamination. Food crumbs stuck to some of the slices. - An unlabeled plastic bag, of what Staff GG identified as bologna, had been opened but not sealed. - 1 - 16 oz opened black cherry Plus Two supplement with no open date. There were 3 more unopened 16 oz black cherry Plus 2 cartons and 1 - a 16 oz vanilla Plus 2 carton, none of which identified a thaw date. The product label identified manufacturer directions to use the product within 14 days of thawing. - 22 - 4 oz chocolate Mighty Shakes with no thaw date identified on the cartons. . The product label identified manufacturer directions to use the	F 812		

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F 812	Continued From page 67 product within 14 days of thawing. During an interview on 12/17/19, at 7:40 a.m., the Dietary Manager verified staff are directed to check temperatures in the walk-in refrigerator and freezer daily but currently do not have a log to document the checks. During an interview on 12/19/19, at 8:50 a.m., the Dietary Manager reported dietary staff are supposed to date the cases of Plus 2 and Mighty Shakes when they are stored in the freezer but acknowledged he did not know the Plus 2 and Mighty shakes had a 14 day shelf life after thawed. He acknowledged the dietary staff should label and date all items stored in the walk-in refrigerator and open packages should be sealed and not left open to air. Review of an undated facility policy titled "Dietary Food Safety Requirements", revealed in part "... Store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Storage of foods brought to residents by family and other visitors will be handled to ensure safe and sanitary storage, handling, and consumption ..." Review of an undated facility policy titled "Food Brought in By Others", revealed in part " ... Food will be dated and marked with the residents name and date received ... Potentially hazardous foods will be dated appropriately and then discarded by facility staff in three days if not consumed ..." 10. The walk-in freezer floor had debris scattered across the floor, including a large amount of frozen peas and green beans in the back right corner, scattered scraps of paper, an ice cream	F 812		

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F 812	Continued From page 68 cup, a cookie dough ball and cardboard remnants. There was a build up of ice on the ceiling, just inside the door, at the back near the freezer coils/fans and on the top left shelf, just inside the door. The top left shelf had 4 boxes of ice cream sandwiches on the shelf, two of which were stuck in the ice and there were chunks of ice scattered across the floor. The freezer door sill appeared soiled with food debris, paper scraps and an area the entire length of the sill and approximately 2-3 inches wide, showed degraded metal and appeared rusty. 11. Two 6# rolls of Farmland pork sausage laid in a bus tub by the oven. The surface of the rolls felt cool touch. A box sat next to the bus tub, which contained 4 - 5# packages of ground beef. The box felt cool to the touch. Observation on 12/16/19, at 11:28 a.m., revealed the same items remained on the shelf next to the oven. Observation on 12/16/19, at 12:30 p.m., revealed the same items remained on the shelf next to the oven. During an interview at the time, Staff HH, cook, reported the pork sausage and hamburger had been laid out by the Assistant Manager previous to her arrival this morning and not sure how long it had been there. She acknowledged there were four of the pork sausage rolls and she used two of them for the pasta bake served at the noon meal. During an interview on 12/16/19, at 1:10 p.m., the Dietary Manager reported the ground beef came in on the truck that morning and likely left out by the staff person present to start thawing for meatloaf tomorrow. He reported the pork	F 812		

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F 812	Continued From page 69 sausage likely left out so it would be thoroughly thawed for lunch today. Upon inspection, the ground beef remained frozen. Upon request the Dietary Manager measured the temperature of the pork sausage which measured 59.4 degrees. During an interview on 12/16/19, at 8:09 p.m., the Staff JJ, Dietary Maintenance reported he checked in the truck delivery early this morning and left the ground beef out to begin thawing for tomorrow and took the pork sausage out of the walk-in refrigerator and left at room temperature to ensure it fully thawed for use at the lunch meal. During an interview on 12/19/19. at 8:50 a.m., the Dietary Manager confirmed his expectation would be to thaw meat under refrigeration, not at room temperature. Review of an undated facility policy titled "Dietary Department" revealed in part " ... Frozen foods are to be thawed at refrigeration temperatures of 41 degrees F [Fahrenheit] or lower. 12. The countertop on the north wall cabinets, to the right of the steamtable, had chipped areas in the formica on corners and edges and the backslash lacked a seal against the wall, which allowed entry of food debris and spills. The wall above the countertop had dried food splatters. The countertop, above the steam table, had chips out of the formica on both corners and a plastic strip attached to the entire length of the countertop had residue and stained areas along the top edge and underneath the plastic strip the entire length. 13. The cook's table, next to the stove, held steamtable pans on the bottom shelf and stored	F 812		

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F 812	Continued From page 70 with the food contact surfaces upward. The top pans had crumbs and debris inside. The front edge of the shelf had areas of dried food residue. 14. The counter on the west wall had quarter round along the edge of the backsplash, with a wide bead of caulk along the entire length of the bottom and what appeared to be a strip of cove base at the top of the quarter round. The surfaces did not create a seamless surface which allowed for the cracks and crevices to hold grime and food debris.. The caulk, quarter round and wall had dried food debris and splatters along the entire length. 15. The west wall above the metal table, next to the cabinets, had dried food splatters extending upward to and around the fire suppression system control box. 16. The large plastic tray and silverware cart had two melted areas on the back right side with one area near the bottom and the other near the top. Both areas had melted through the plastic and had cracks and crevices in the plastic surface, The top melted area had a horizontal crack extending approximately 8" toward the front, creating a gap to expose the material underneath. Below the crack, the melted plastic had slid downward and hardened, creating a rough surface, approximately 5" X 4". The melted area near the bottom had two small horizontal cracks, extending toward the front, approximately 2" and the melted plastic had bubbled up with small gap near the cracks, exposing the material underneath. During an interview on 12/16/19, at 11:14 a.m., Staff GG, confirmed the cart had been left too close to the oven and melted the two areas.	F 812		

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F 812	Continued From page 71 Observation on 12/17/19, at 7:40 a.m., revealed the environment/cleaning issues identified on the previous day remained the same, except the soiled rag had been removed from the hand sink, the meat no longer remained at room temperature and the pool of light brown liquid had been cleaned up but a large bulk container of sugar, in the dry storage room, had the lid removed and open to potential contamination. During an interview on 12/17/19, beginning at 2:00 p.m., conducted a walk through of the kitchen to review the environmental concerns with the Administrator, Dietary Manager and Consultant Dietitian.. All of the environment concerns identified yesterday morning remained except a different rag was in the hand sink and the light brown liquid on the walk-in floor had been cleaned up. The bulk sugar bin in the dry storage room remained uncovered. During an interview on 12/18/19, at 8:50 a.m., the Administrator acknowledged she has not been in the kitchen other than just inside the door, since her employment began at the facility in November . She confirmed the kitchen had multiple environmental concerns and confirmed the department lacked routine cleaning and maintenance issues. During an interview on 12/19/19, at 8:50 a.m., the Dietary Manager acknowledged the current posted cleaning list in the kitchen is November's had not yet posted December's. He acknowledged the staff needed education on how to document on the form, as some are recording comments of what they completed and not initialing by the items identified. He reported he	F 812		

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F 812	Continued From page 72 plans to do further work on cleaning schedules to be sure and identify all areas and necessary frequencies. He reported he has completed some cleaning in the kitchen since Tuesday afternoon but confirmed multiple cleaning concerns remained and the the current conditions have developed over a period of time from the lack of an effective cleaning program. During an interview on 12/24/19, at 8:30 a.m., the Dietary Manager reported he does not have any defined cleaning procedures for the the kitchen environment or equipment. Review of an undated document titled "Daily Cleaning Schedule", revealed cleaning tasks identified for the various dietary positions, some of which included walk-in, small sinks, dishmachine line and full kitchen mop. Staff had initialed by only a few items on the schedule and recorded a few comments. The schedule lacked any initials for cleaning the hand sink or mopping the floor, had one date initialed for walk-in and two for the dishmachine. Review of an undated policy titled "Dietary Department", revealed in part " ... Keep all work areas, the floor and dietary equipment as clean as possible throughout the work day ... Wet mop floors every day and when needed ... Clean an sanitize storage facilities for raw and cooked food every week ... At least every month clean ... dishwashing machines ... Every day, check temperatures of refrigerators, freezers ... " Review of an undated document titled "3-9 Drink Aide", identified the daily responsibilities of the position which included in part " ... You seep and the PM cook mops ...".	F 812		

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F 812	Continued From page 73 Review of an undated document titled "Dishwasher Am/PM", identified the daily responsibilities of the position which included in part " ... You are responsible for your part of the cleaning list ...". Review of an undated document titled "Cooks 5-1 & 1-9", identified the daily responsibilities of the position which included in part " ... Share the responsibility of sweeping, mopping and taking out the trash ...". Review of an undated document titled "Dishwasher Am/PM", identified the daily responsibilities of the position which included in part " ... You are responsible for doing your cleaning list ... After all dishes are done, clean ... the wall and the door ... Clean the top and outside of dish machine, empty both filters, and clean the dirty and clean sides ... sweep, mop ... ". II. Observation on 12/16/19, at 9:50 a.m., revealed the dishmachine in operation. The data label identified a minimum wash and rinse temperature of 120 degrees and a minimum concentration of 50 parts per million (ppm) chlorine sanitizer. Observation of the dishmachine showed an actual wash and rinse temperature of 90 degrees per machine temperature gauge. The Dietary Manager reported they had noticed the temperature had been measuring low and the dishmachine technician identified the problem during routine service in November, with a part ordered ordered at that time. Upon request, Staff FF, dietary aide, tested the water at the end of the rinse cycle to measure the chlorine sanitizer concentration with	F 812		

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F 812	Continued From page 74 . The test strip showed no color change. Staff FF reported it's supposed to be purple but added he thought "maybe" matched the color for 50 ppm when compared to color chart on the test strip package. He ran another load and tested the rinse water but the strip showed no color change. Upon examination of the chlorine test strip container, the product label identified an expiration date of 10/1/19. The Dietary Manager reported he would call the dishmachine service technician to report the lack of sanitizer and check on the part needed to correct the temperature issue. Staff FF continued to operate the dishmachine and finished the soiled dishes from breakfast. During an interview on 12/16/19, at 10:45 a.m., Staff FF reported the dishmachine has been at about for 90 degrees a couple months. He reported that a test strip is supposed to be checked mid morning and mid afternoon and the color on the test strip has not been the usual purple for probably a month. Observation on 12/16/19, at 10:51 a.m., the Dietary Manager reported he had contacted the dishmachine technician who confirmed the part to correct the temperature issue had been ordered. The Dietary Manager relayed the technician told him he is 3 hours away not sure he can come to check out the sanitizer issue. Upon further inspection of the dishmachine the Dietary Manager realized the plastic tubing, in the chlorine sanitizer bucket, failed to reach the solution and he pushed it all the way down. He ran a cycle to see if the tubing drew up any sanitizer solution observation revealed the tubing had air bubbles in it. The Dietary Manager checked the rinse water with a chlorine test strip	F 812		

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F 812	Continued From page 75 and it continued to fail to measure any presence of chlorine. He reported he would contact the dishmachine technician again and see if he come to the facility and check the machine. Observation on 12/16/19, at 11:14 a.m., revealed the dietary staff continued to use the dishmachine and Staff FF reported he had not checked another test strip to see if any solution dispensed into the rinse water. Observation on 12/24/19, at 11:45 a.m., discovered the test strips, currently used for the dishmachine are labeled for iodine. During an interview at the time the Dietary Manager reported he would call their service company and attempt to obtain the correct ones as the ones he had ordered to come in today, did not arrive on the truck. During an interview on 12/16/19, at 1:55 p.m., the Dietary Manager reported the dishmachine technician has not been in the facility to check the machine. Upon request, Staff FF tested the dishmachine rinse water and the test strip now showed a measure of 100 ppm. During an interview on 12/19/19. at 8:50 a.m., the Dietary Manager reported he has not been informed of a timeframe for the repair of the dishmachine temperature issue. He reported he sent a message to their food/chemical representative to get a status report the part, since it was ordered over a month ago. The Dietary Manager acknowledged they continue to use the same test strips (with an expiration 10/1/19) and planned to order new ones today, which will arrive the delivery on Monday.	F 812		

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F 812	Continued From page 76 During an interview on 12/16/19, at 4:10 p.m., the Dietary Manager reported dietary staff are expected to check the dish machine twice daily and document the results of wash/rinse and test strip on the form provided in the dishroom area. Review of an undated policy titled "Dietary Department", revealed in part " ... Every day, check temperatures of dishwasher rinse cycles ... Review of documents reported by the Dietary Manager to be the dishmachine logs, revealed June had 9 checks documented, July and August had 1 check each documented, September had no checks document, November had 5 checks documented and December had morning checks documented consistently through 12/16/19 (day of entrance). Review of a report from the dishmachine technician, dated 11/8/19, revealed the technician determined the booster heater failed and indicated he would order the part. A report dated 12/17/19 confirmed the part had been ordered, but did not indicate the date. During an interview on 12/24/19, at 12:15 p.m. the Dietary Manager reported he contacted their dishmachine representative who verified the iodine strips would not be effective in verifying chlorine concentration. He reported the iodine strips were here when he started and hasn't had to order any new ones. He will check with area facilities to see if there would be some he could borrow until their next food delivery . III. 1. Observation on 12/16/19, at 11:41 a.m., revealed Staff II, cook, assigned to measure food temperatures and serve the noon meal. During	F 812		

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F 812	Continued From page 77 an interview at the time, Staff II reported she planned to measure the temperature of the pureed lasagna first, but thought it wouldn't be up to the "normal" since it had just been pureed and put in the steamtable. She measured the pureed lasagna at 122.1 degrees. Staff II reported the expected temperature would be about 165 degrees. She measured the pureed tossed salad at 44.7 degrees and the regular tossed salad at 39.2 degrees!. Staff II kept the lettuce salad and pureed lettuce salad on a cart, near the steamtable absent of any temperature control and began meal service at 11:52 a.m. Observation on 12/16/19, at 1:00 p.m., revealed noon meal service ended and upon request, Staff II, measured temperatures of cold and hot foods left. The lettuce salad measured 54.9 degrees, the pureed lettuce salad measured 55.2 degrees, and the pureed pasta measured 123 degrees. During an interview on 12/16/19, at 4:10 p.m., the Dietary Manager acknowledged staff are supposed to check all food temperatures at each meal and document them on the temperature record. During an interview on 12/23/19, 9:10 a.m., the Dietary Manager, report the expectation for food temperatures on steam table are 165 degrees or above for hot food and 40 degrees or below. He acknowledged cold food items should be put on ice for meal service to maintain the temperature, either in a bowl to the side or ice bath in a steamtable well. Review of facility documents titled "Food Temperature Records", from 11/26/19 through 12/19/19 revealed the dietary staff failed to	F 812		

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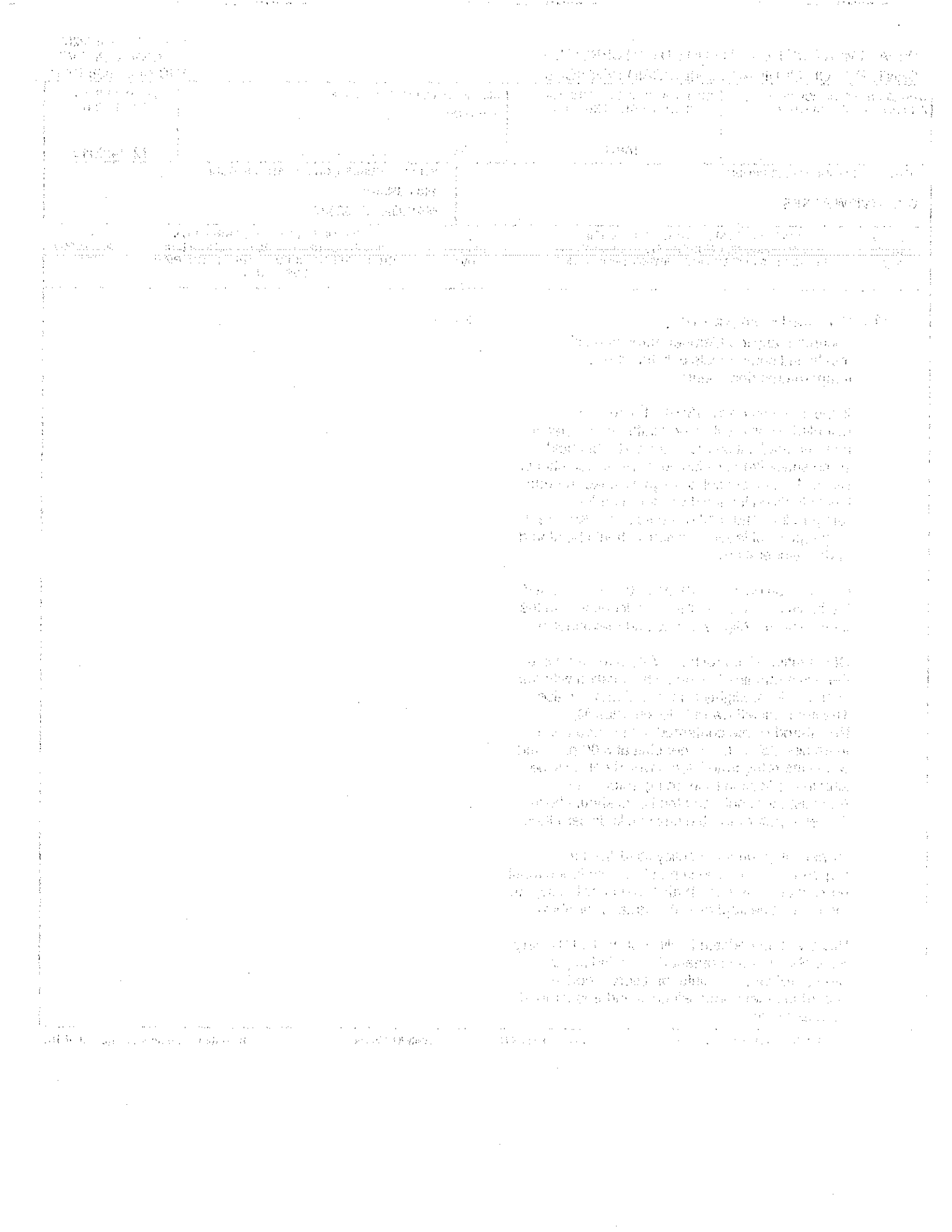
F 812	Continued From page 78 document any food temperatures at multiple meals and some meals only had 1 or 2 temperatures documented. 2. Observation on 12/16/19, at 3:40 p.m., revealed a basin sat at the south nurses station, near the medication room door. The bin held some snack items including 22 American cheese slices, 1 - 4 oz chocolate Mighty Shake (product label identified it should be stored under refrigeration) and a 12 oz container of Kraft real mayo (product label identified it should be stored under refrigeration). Observation on 12/16/19, at 4:20 p.m., revealed the basin remained in the same location with the cheese slices, Mighty Shake and mayonnaise. Observation at 12/16/19, at 7:46 p.m., revealed the basin remained in the same location with the cheese slices, Mighty Shake and mayonnaise. The items all felt warm to touch. Staff M, Registered Nurse confirmed the bin had been there since she started her shift at 6:00 p.m. and would the refrigerated items would normally be kept in medication room refrigerator. The Administrator confirmed the items should be in the refrigerator reported she would discard them. Review of an undated policy titled "Dietary Department" revealed in part " ... Cold foods must be kept at 41 degrees [Fahrenheit] For below; hot foods must be kept at 140 degrees F or above ..." Review of an undated facility policy titled "Dietary Food Safety Requirements", revealed in part "... Store, prepare, distribute, and serve food in accordance with professional standards for food service safety.	F 812		



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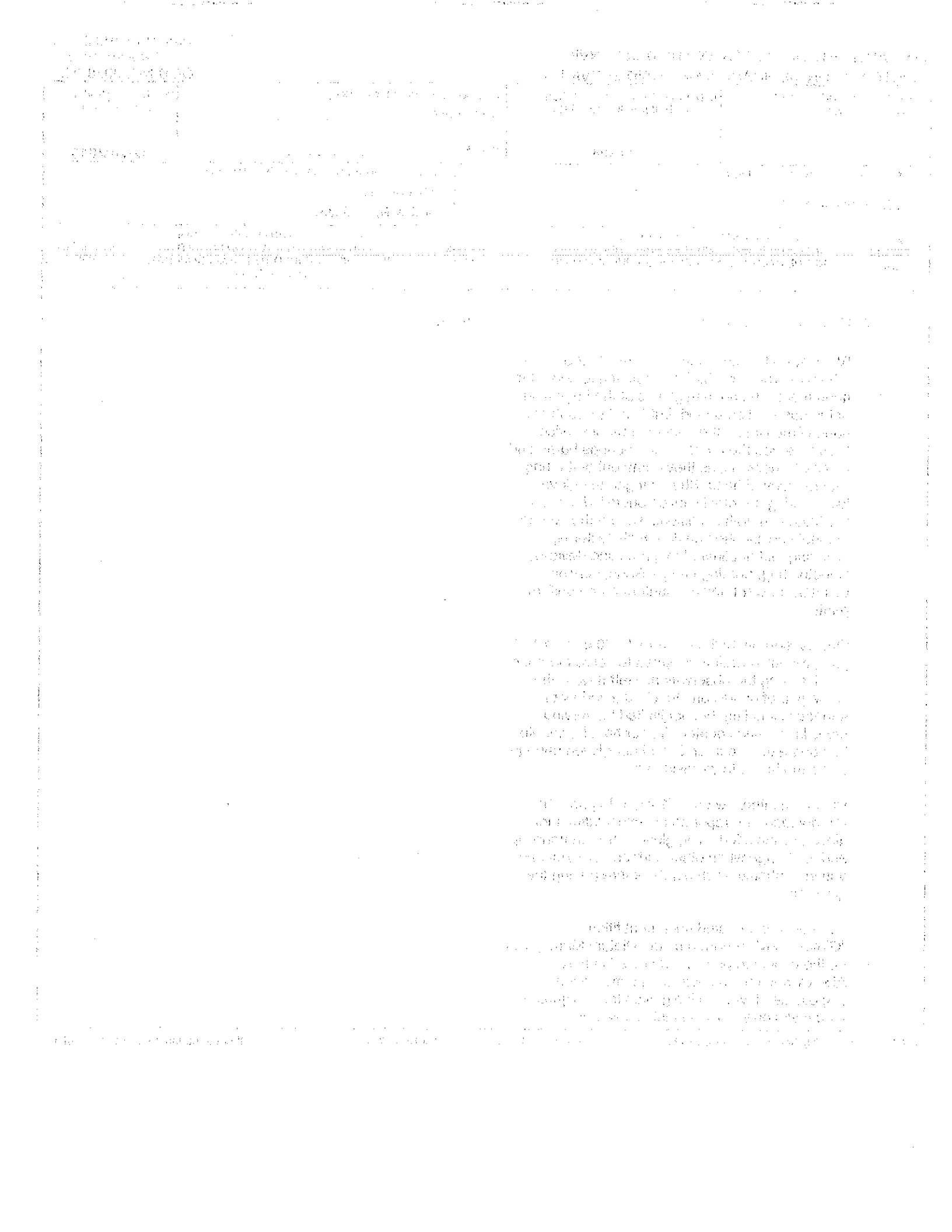
F 812	Continued From page 79 IV. Observation on 12/16/19, from 11:52 a.m. to 1:00 p.m., revealed Staff II, assigned to serve the noon meal. She donned gloves at the beginning of the observation period, but failed to wash her hands first. During the course of meal service, Staff II served the garlic toast, hot dogs burns and touched Cheetahs, as they came out of the bag, with her gloved hand. She changed the glove twice during the meal service but failed to wash her hands on both occasions. During the course of meal service she handled multiple items, including, but not limited to, portioning devices, Cheetos bag, hot dog bun package, serving counter, drawer handle, countertop and uniform pants. Observation on 12/17/19, from 12:30 p.m. to 1:15 p.m., revealed Staff II assigned to serve the noon meal. During the observation, Staff II wore the same pair of gloves and touched a variety of surfaces including, but not limited to, serving utensils, serving counter, drawer handle, cheetos bag and a utility cart and used her gloved hand to serve the bread to 31 residents. During an interview on 12/16/1, 1:35 p.m., the Dietary Manager reported his expectations for glove use included using gloves for food handling and to change when other surfaces are touched and staff should wash hands before putting the glove on. Review of an undated document titled "Glove-ology", reported by the Dietary Manager to be the expected practice, revealed in part "... Always wash hands before and after using disposable gloves ... Use gloves for designated food tasks only ... Disposable gloves are	F 812		



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F 812	Continued From page 80 task-specific and should never be worn continuously, Always wash hands between glove change ..." V. Observation on 12/17/19, at 11:52 a.m., revealed the dementia unit cart trays had been prepared for transport to the unit. dietary staff covered the plates of food but failed to cover the drink glasses, dessert cups and salad dressing cups. The cart of trays left the kitchen and transported through the hallway to the dementia unit and the drink glasses, dessert cups and dressing cups remained uncovered. Observation on 12/16/19, at 12:35 p.m. revealed room tray meal service started. dietary staff covered the plates of food but failed to cover the glasses, dessert cups and salad dressing cups. The room tray carts left the kitchen and transported through the hallway to rooms on the 100, 300 and 400 hallways while the drink glasses, dessert cups and dressing cups remained uncovered. Observation on 12/17/19, at 12:55 p.m., revealed the 100 hall cart room trays dished and ready to go out. The dietary staff covered the plates failed to cover the drink glasses and dessert dishes on all 4 trays. The cart left kitchen and dietary aide proceeded down the hall with the uncovered items. Observation on 12/17/19, at 1:08 p.m., revealed, the room trays for the 300/400 halls dished and ready for transport. dietary staff covered the plates but failed to cover the drink glasses and dessert dishes. The room tray cart left the kitchen and proceeded into the hallways with the uncovered drink glasses and dessert dishes.	F 812		

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F 812	Continued From page 81 During an interview on 12/19/19, at 8:50, the Dietary Manager reported he was unsure of the requirements for covering food/beverages for transport through the halls and asked he first started and received varying answers. Review of an undated facility policy titled "Dietary Department" revealed in part " ... Transport food to other areas using closed food carts and covered containers: food is to be kept covered during transport ... When a tray is being transported, it is necessary for all food to be kept covered ..." VI. Observation at 12/17/19, 7:45 a.m., revealed a large bulk container of sugar, in the dry storage room, had the lid removed and left open to potential contamination. Observation on 12/17/19, at 12:30 p.m., revealed the sugar bin in dry storage room remained uncovered. Observation on 12/17/19, at 2:00 p.m., revealed the bulk sugar bin in the dry storage room remained uncovered. During an interview at the time, the Dietary Manager put the lid back on and reported it should not be left off. The 2013 Food Code, published by the Food and Drug Administration and considered a standard of practice for the food service industry, requires food employees to wash hands prior to donning gloves and single-use gloves be used for only one task, such as working with ready-to-eat food and used for no other purpose and discarded when damaged or soiled, or when interruptions	F 812		

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F 812	Continued From page 82 occur in the operation. The 2013 Food Code, published by the Food and Drug Administration and considered a standard of practice for the food service industry, requires time/temperature control for safety of certain foods (TCS), which include: an animal food that is raw or heat-treated, a plant food that is heat-treated or consists of raw seed sprouts, cut melons, cut leafy greens, fresh cut tomatoes or mixtures of fresh cut tomatoes. The TCS foods must be marked with a date the items are stored and a label to identify the contents. The 2013 Food Code, published by the Food and Drug Administration and considered a standard of practice for the food service industry, requires TCS foods be thawed under refrigeration that maintains the food temperature at 41 degrees Fahrenheit (F.) or less, completely submerged under running water at a temperature of 70 degrees F or less, as part of the cooking process or thawed in a microwave oven and immediately transferred to a conventional cooking equipment. The 2013 Food Code, published by the Food and Drug Administration and considered a standard of practice for the food service industry, requires TCS foods be held for service at 135 degrees or above or 41 degrees or below. The 2013 Food Code, published by the Food and Drug Administration and considered a standard of practice for the food service industry, requires non-food contact surfaces of equipment that are exposed to splash, spillage or food soiling be constructed of a corrosion-resistant, nonabsorbent and smooth material and the surfaces must be free of unnecessary ledges,	F 812		

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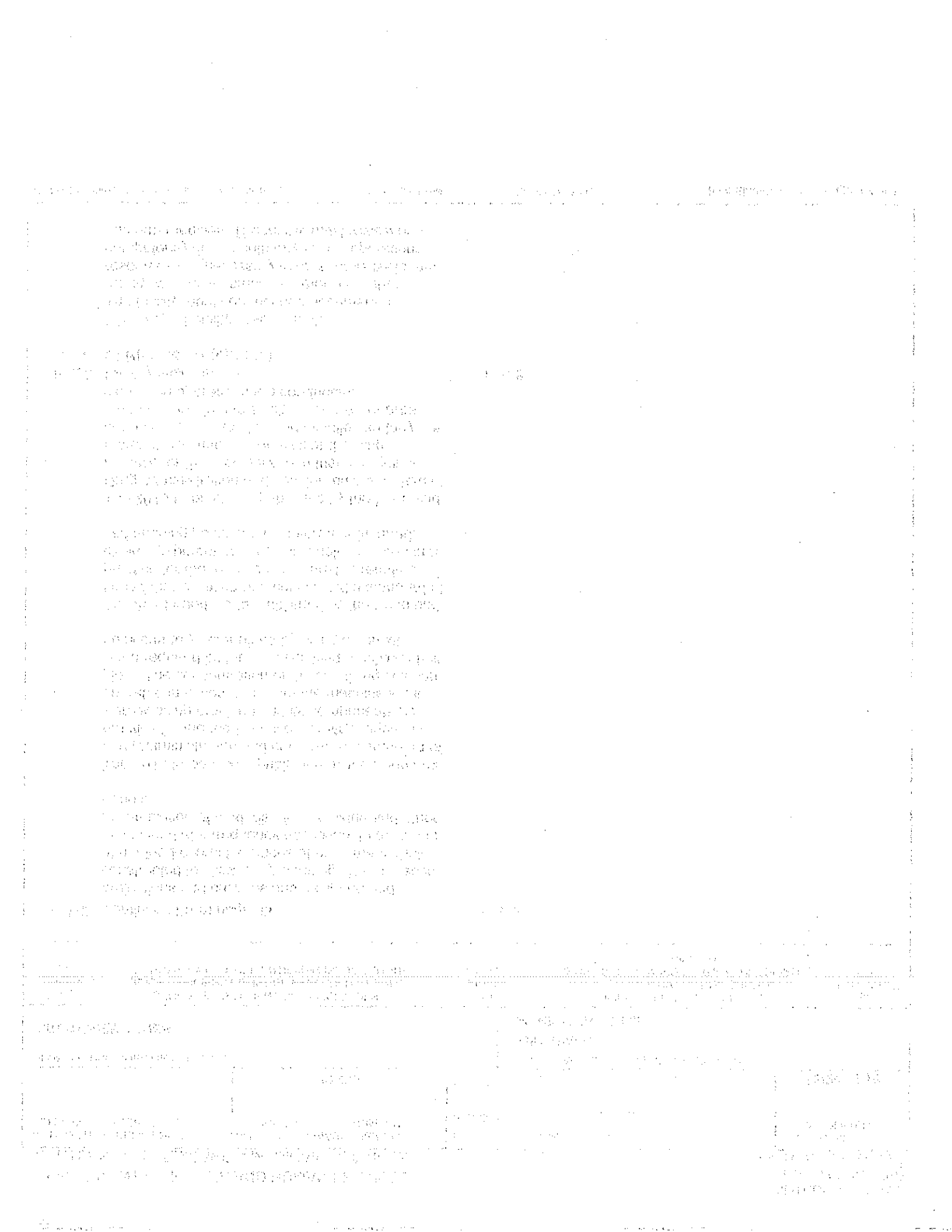
F 812	Continued From page 83 projections and crevices and designed and constructed to allow easy cleaning. The surfaces of nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to avoid the accumulation of dust, dirt, food residue and other debris. The 2013 Food Code, published by the Food and Drug Administration and considered a standard of practice for the food service industry, requires a warewashing machine and its components be operated in accordance with the machine's data plate. The concentration of the sanitizing solution, when required by the warewashing machine shall be accurately determined by using a test kit. The 2013 Food Code, published by the Food and Drug Administration and considered a standard of practice for the food service industry, requires clean equipment and utensils shall be stored in a self-draining position and covered or inverted. The 2013 Food Code, published by the Food and Drug Administration and considered a standard of practice for the food service industry, requires materials for indoor floor, wall and ceiling surfaces be constructed and installed so they are smooth, durable and easily cleanable for areas were food operations are conducted.	F 812		
F 838 SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and	F 838		



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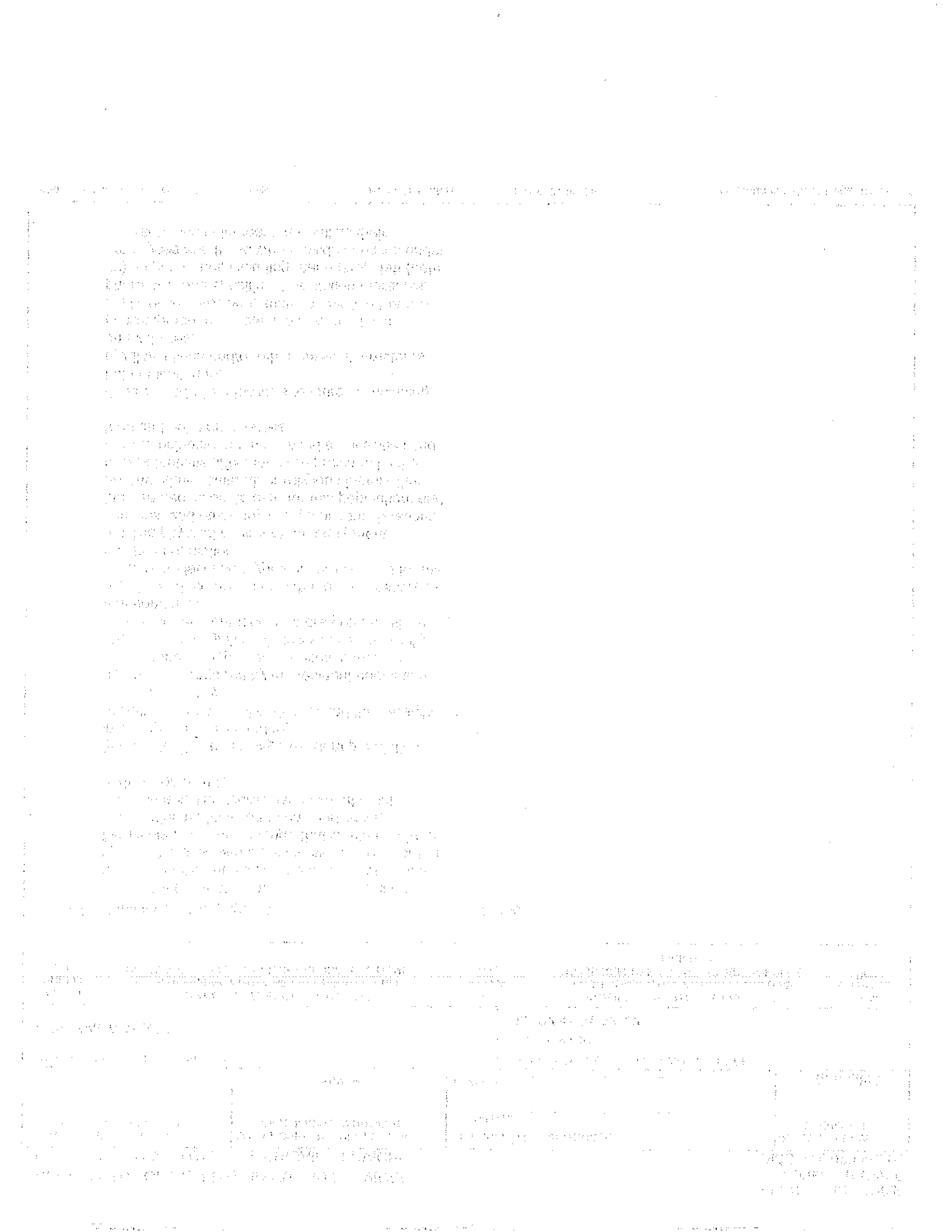
F 838	Continued From page 84 update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their	F 838		



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F 838	Continued From page 85 education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview the facility failed to include the required individuals and identify their licensed Chronic Confusion or Dementing Illness(CCDI) unit, with associated training needs, when developing their facility assessment. The facility identified a census of 74 residents. Findings include: Review of a document titled "Facility Assessment, dated 8/17/19. The document identified the people involved in the assessment as the previous Administrator and previous Director of Nursing but lacked documentation to show involvement from the governing body and Medical Director or other individuals that would be important to ensure a thorough assessment of the needs of the resident population and the required resources needed to meet their needs. The assessment identified they accept residents with several common diseases/conditions and identified various topics of education provided but	F 838		

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F 838	Continued From page 86 failed to identify their CCDI unit and the associated training needs for the specialized population accepted. During an interview on 12/23/19, at 8:10 a.m., the Administrator reported she had not had a chance to review the current facility assessment since her employment at the facility but acknowledged the current facility assessment appeared short and lacked detail specific to the facility.	F 838		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		

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F 880	Continued From page 87 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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F 880	Continued From page 88 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the facility failed to maintain infection control while transporting laundry, for 2 out of 2 catheters cares reviewed (Resident # 13 and # 8), sanitization of 3 out of 3 blood glucose meters (Resident # 6, #47 and # 30), 1 out of 1 for wound care (Resident # 35) and peri care for 1 out of 2 (Resident # 44) . The facility reported a census of 74 resident. Findings included: 1. During a observation on 12/17/19 at 6:55 a.m., Staff OO Laundry pushed an uncovered basket on wheels with stacked incontinence pads down the 300 hall. During an observation on 12/17/19 at 8:14 a.m., Staff OO pushed a hanging laundry cart with 1 of 4 sides uncovered from the center Nurses Station all the way down 300 hall. At 8:18 a.m., as Staff OO delivered laundry she moved the open laundry cart back up the 300 hall one room at a time, while resident and staff passed by the open hanging laundry cart. During an observation on 12/17/19 at 8:42 a.m., Staff housekeeping sprayed a table in the Unit with Spic and Span foam cleaner and immediately wiped the chemical off with a white towel. During an observation on 12/17/19 at 4:22 p.m., a Certified Nurses Aid (CNA) walked out of a resident room on 300 hall caring an un-bagged large hand full of urine smelling laundry,	F 880		

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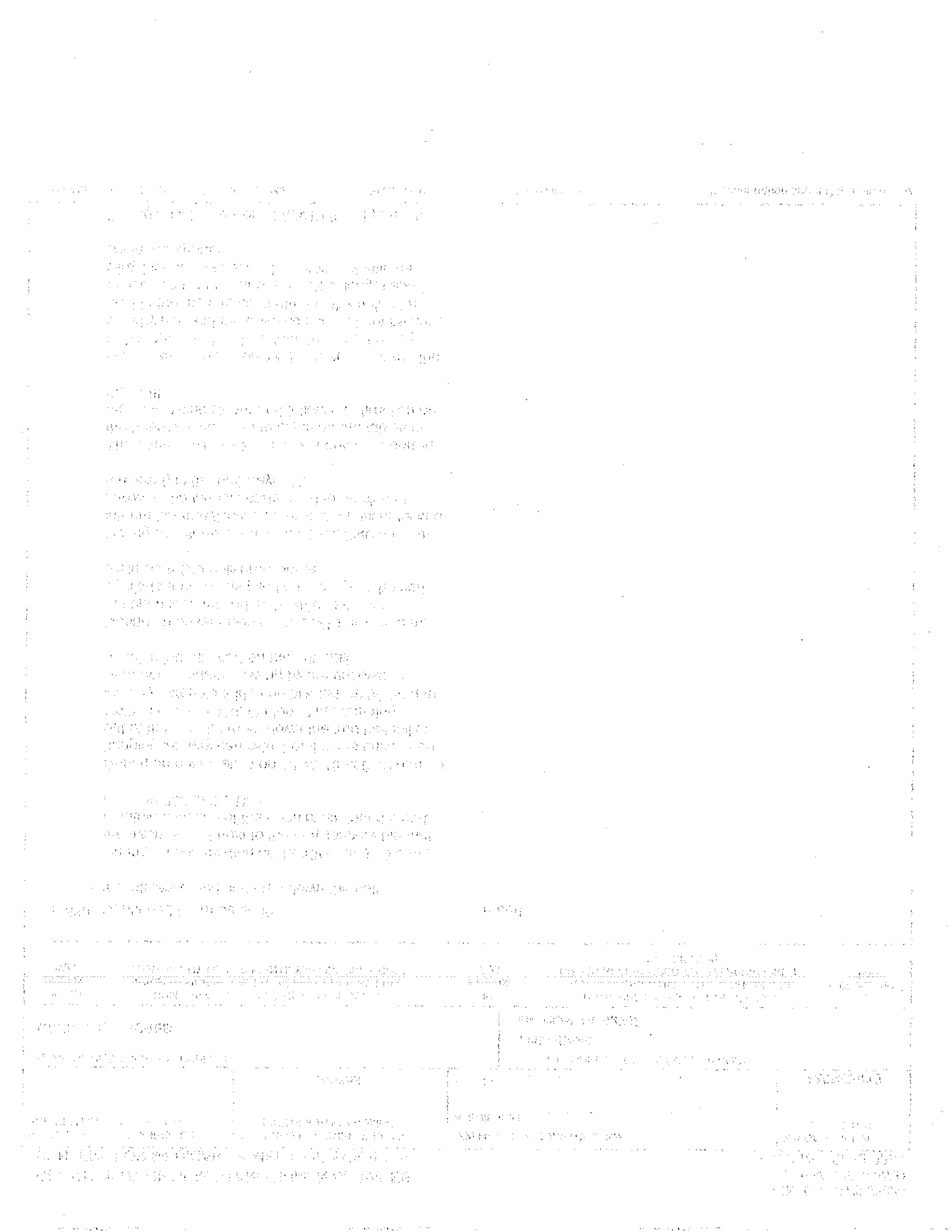
F 880	Continued From page 89 incontinence pad and brief down the hall. During an observation on 12/18/19 at 8:30 a.m., the trash bin sat next to the dirty laundry bin that is within 3 inches of the open clean laundry cart by room 206 in the Unit. During an observation on 12/18/19 at 8:49 a.m., a hanging laundry cart with 1 of 4 sides uncovered out of the laundry room down the 100 hall full of clothes to room 118. On top of the hanging laundry cart held folded up blanket. At 08:58 a.m., Staff and resident passing by the uncovered hanging laundry cart on the 100 hall. During an observation on 12/23/19 at 7:29 a.m., the open laundry cart in the 400 hall with blankets and sheets piled on the top of the cart while Staff OO delivered clothes. During an interview on 12/23/19 at 8:40 a.m., the interim Laundry/Housekeeping Supervisor lacked knowing the laundry carts need to be closed (covered) in the hall ways. The The Laundry/Housekeeping supervisor reported the housekeepers are to clean off the tables in the Unit Dining Room and follow the direction on the bottle. During an interview on 12/23/19 at 3:31 p.m., the DON reported the clean laundry cart, the dirty laundry bin, and the trash can should not be right next to the next to each other in the hall. The expectation is the carts are a door length apart. Dirty laundry is expected to be in a plastic bag when transported During an interview on 12/23/19 03:04 p.m., the	F 880		



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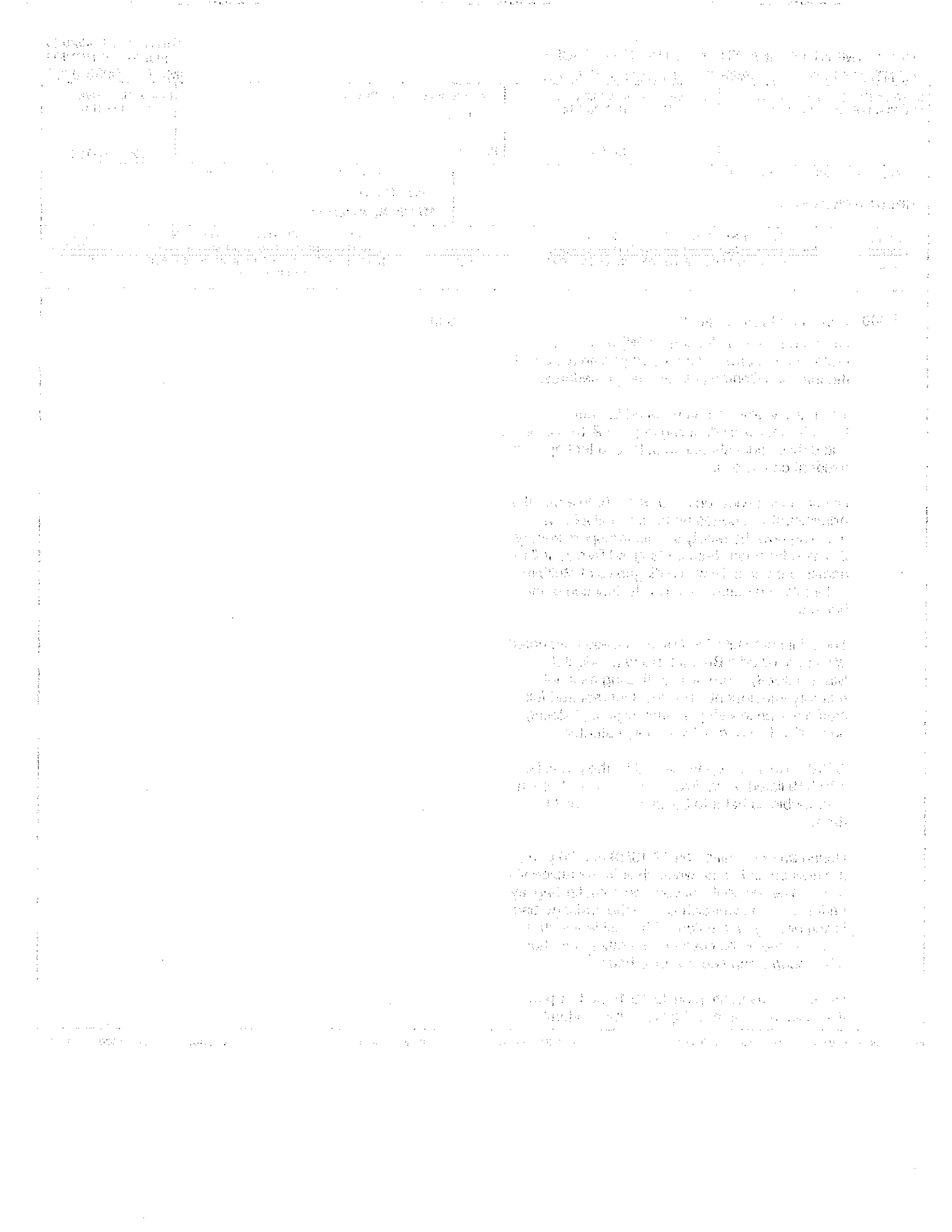
F 880	Continued From page 90 interim Director of Nursing (DON) unable to locate the documentation the Physician reviewed the Infection Control policies and procedures. The Facility provided an undated Laundry Department Policy directing at point # 10- Clean and dirty laundry should be at least 6 feet apart in resident care areas. During an interview on 2/24/19 at 10:09 a.m., the Administrator reported no policy available on directing how the facility should transport laundry. 2. The Admission Record identified Resident #13 admitted on 2/26/19 with a diagnosis of Multiple Sclerosis and neuromuscular dysfunction of the bladder. The Minimum Data Set (MDS) Assessment dated 9/11/19 showed a Brief Interview for Mental Status (BIMS) score of 11 indicating minimal memory impairment. The resident required full staff assistance with personal hygiene, toileting and utilized a suprapubic urinary catheter. A Order Review Report, signed by the physician 12/11/19 listed a physician order for a 20 French suprapubic catheter to be changed every 28 days. During an observation on 12/16/19 at 2:20 p.m., the resident sat in the wheelchair in the resident's room. The resident's uncovered catheter bag lay underneath the wheelchair with the drainage bag laying directly on the floor. The resident stated, "my bag should be covered. It bothers me that other people can see my urine bag." During an observation on 12/16/19 at 8:11 p.m., the resident lay in bed supine. The resident's	F 880		



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F 880	Continued From page 91 uncovered urinary drainage bag lay on the floor under the bed. During an observation on 12/17/19 at 4:34 p.m., the resident lay in bed supine. The resident's uncovered urinary drainage bag lay on the floor under the bed. During an observation on 12/18/19 at 7:15 a.m., the resident lay in bed supine. The resident's uncovered urinary drainage bag lay on the floor under the bed. The Care Plan, with an initiation date of 3/19/19, identified the resident utilized a suprapubic catheter for urinary elimination and directed staff to use proper placement of bag (urinary) for urine flow-gravity. During an interview on 12/18/19 at 11:32, Staff U, Certified Nursing Assistant (CNA), reported urinary drainage bags should be covered when the resident is out of the room and the uncovered bag and tubing should never touch the floor. She stated she had not been instructed the urinary drainage bag should be covered when the resident is in their room for dignity. During an interview on 12/18/19 at 1:58 p.m. Staff Z, Registered Nurse (RN), reported urinary drainage bags should be covered for dignity and the bags should never come into contact with the floor. During an interview on 12/18/19 at 4:31 p.m., the Interim Director of Nursing (DON), stated urinary drainage bags should be below the level of the bladder, not contact the floor and be covered with a privacy bag.	F 880		

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F 880	Continued From page 92 The undated Catheter Care (Indwelling Catheter) Policy, provided by the facility did not address the use of privacy bags for dignity or direct staff to keep the urinary drainage bags from contacting the floor to prevent infection. The undated Catheter Drainage/Specimen Collection Policy, provided by the facility did not address the use of privacy bags for dignity or direct staff to keep the urinary drainage bags from coming into contact with the floor to prevent infection. 3. The Minimum Data Set (MDS) Assessment for Resident #8, dated 9/5/19, documented a Brief Interview for Mental Status score of 4, indicating severe cognitive loss. The resident required extensive assist for dressing, toileting and personal hygiene. The MDS showed the resident used a suprapubic catheter for a diagnosis of benign prostatic hyperplasia (BPH). The Order Review Report, signed by the Advanced Registered Nurse Practitioner (ARNP) on 12/11/19, identified an order for a 22 French 10 milliliter catheter to be changed monthly. The Care Plan, with a revision date of 4/13/18, documented the resident required a suprapubic catheter for urinary elimination. During an observation on 12/18/19 at 12:35 p.m., Staff BB, Certified Nursing Assistant (CNA), assisted resident #8 to his/her room and to the bathroom. Staff BB gloved without performing hand hygiene, opened the urinary leg drainage bag valve and emptied the contents into a	F 880		

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F 880	Continued From page 93 graduate. Staff BB closed the urinary drainage bag valve and cleansed the valve with alcohol. Staff BB placed the graduate half full of urine directly on the floor in the bathroom, then assisted the resident to stand and pull pants down to sit on the toilet. Staff BB picked up the graduate of urine up off the floor, measured and placed the graduate of urine back on the floor without a barrier. Once the resident was done, she emptied the urine into the toilet, rinsed the graduate and stored in a plastic bag in the resident's bathroom to be used again. During an interview on 12/19/19 at 11:20 a.m., Staff U, CNA, reported receiving training when emptying a urinary catheter, and a barrier must be used if the graduate is sat down on the floor. During an interview on 12/19/19 at 11:41 a.m., Staff K, Licensed Practical Nurse (LPN), reported when staff empty a urinary drainage bag a barrier should be used whenever a graduate is placed on the floor. She stated a paper towel should be placed on the floor before sitting the graduate on the floor. During an interview on 12/19/19 at 11:45 a.m., the Interim Director of Nursing (DON), reported a graduate should not be sat on the floor without a barrier underneath to prevent infection. The undated Catheter Drainage/Specimen Collection Policy, provided by the facility did not direct the nursing staff on using a clean barrier before sitting a graduate on the floor to prevent infection. 4. The Transfer/Discharge Report for Resident #	F 880		

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F 880	Continued From page 94 47 identified the resident admitted on 12/15/2015 with a diagnosis of Type Two Diabetes without complications. The Order Review Report, signed by the physician on 12/10/19, identified the resident had a physician order for an accu-check in the morning and evening every four days. During an observation on 12/16/19 at 7:45 p.m., Staff W, Oral Medication Technician (OMT), entered the resident's room to perform the evening accu-check. Staff W laid the blood glucose meter in the resident's bed without a clean barrier and donned gloves. Staff W performed the blood glucose check. Staff W walked out of the room and placed the blood glucose meter on the top of the medication cart. Staff W wiped the blood glucose meter with an alcohol prep pad and placed the meter back in the medication cart. During an interview on 12/16/19 at 7:53 p.m., Staff W reported Resident #47 did not have his/her own blood glucose meter and used a facility shared meter. Staff W stated she had been educated to clean the blood glucose meters with an alcohol pad. 5. The Admission Record for Resident #6 identified the resident admitted on 2/14/2019 with a diagnosis of Type Two Diabetes. The Order Review Report, signed by the physician on 12/11/19, identified the resident had a physician order for an accu-check to be completed before meals.	F 880		

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F 880	Continued From page 95 During an observation on 12/17/19, Staff Y, OMT, assisted Resident #6 to the Nurses Office. Staff Y placed the blood glucose machine on the nurses' desk without a clean barrier and proceeded to perform the resident's blood glucose testing. Staff Y brought the blood glucose machine out of the office and placed directly on top of the medication cart. Staff Y wiped the blood glucose machine with an alcohol prep pad and placed the meter back in the medication cart. 6. The Admission Record for Resident #30 identified the resident admitted to the facility on 12/28/19 with a diagnosis of Type Two Diabetes. The Order Review Report, signed by the physician on 12/10/19, listed a physician order to check blood glucose three times a day for Diabetes Mellitus. During an observation on 12/17/19 at 10:54 a.m., Staff Y entered the resident's room and placed the blood glucose meter on the resident's bed without a clean barrier. The bed spread had a moderate amount of dried bloody drainage noted approximately two inches from where the blood glucose meter had been laid down on the resident's bed. Staff Y stated the resident picks at his/her skin. Staff Y applied gloves without performing hand hygiene, then reported she needed to get another blood glucose meter as the resident's meter did not work. Staff Y left the resident's room to obtain another blood glucose meter. Staff Y came back to the resident's room at 11:00 a.m. with another blood glucose meter and	F 880		

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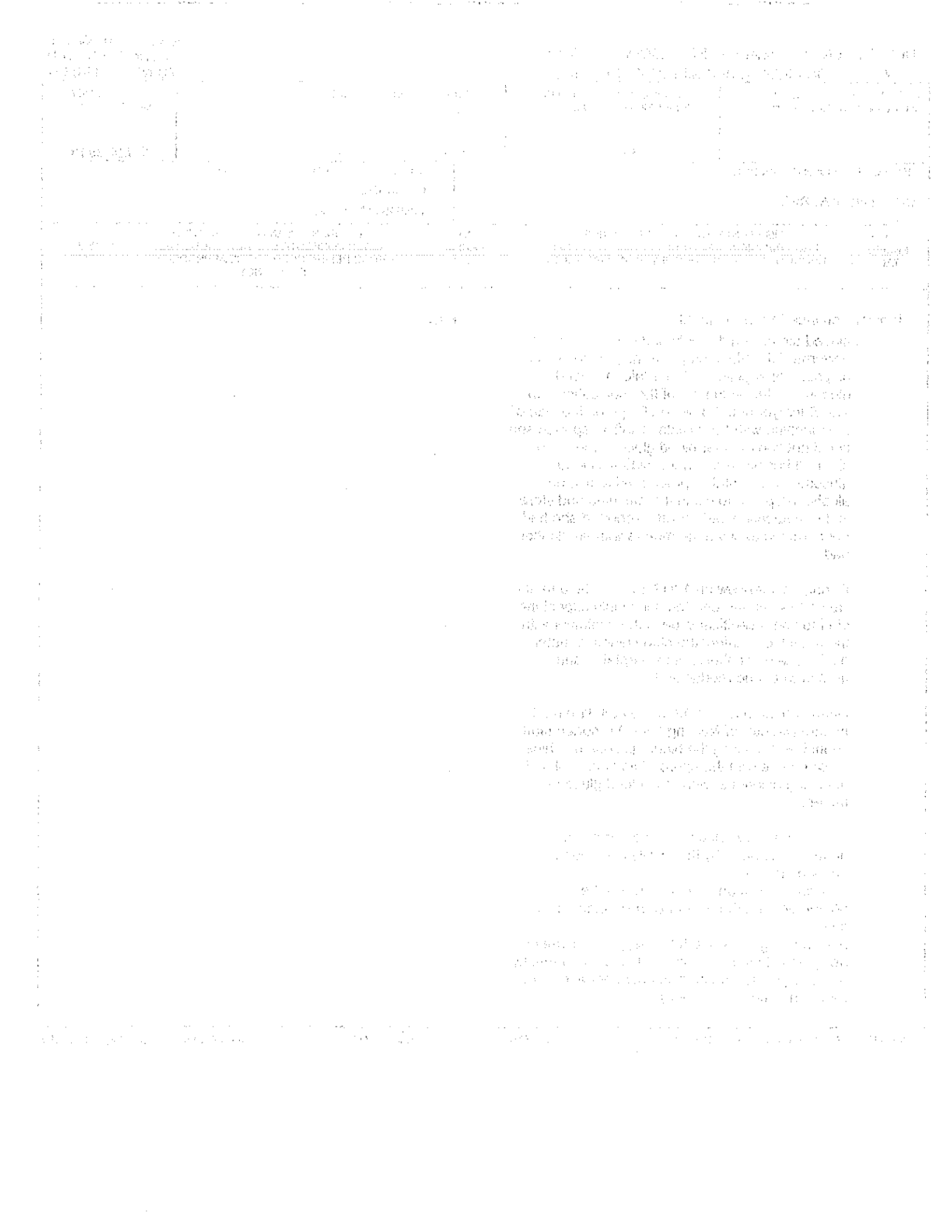
F 880	Continued From page 96 placed directly on the dirty bed spread. Staff Y performed the blood sugar, removed gloves and disposed of supplies. Staff Y laid the blood glucose meter on the top of the medication cart. The Surveyor noted a piece of tape on the side of the machine with two initials. Staff Y reported she could not find another blood glucose meter so she had borrowed another resident's blood glucose meter. Staff Y proceeded to use an alcohol prep pad to clean the machine and store in the medication cart. Staff Y reported she had been trained to clean the meters with an alcohol pad. During an interview on 12/17/19 at 11:38 a.m. the Nurse Consultant reported she would expect the staff to use a sanitizer wipe in the container with the red lid to disinfect the blood glucose meters as the use of alcohol is not acceptable and nurses would be reeducated. During an interview on 12/18/19 at 4:31 p.m. the Interim Director of Nursing (DON) reported staff should be sanitizing the blood glucose machine between use with the appropriate chemical and not using alcohol to clean the blood glucose meters. The Finger Stick Glucose Check Protocol, undated, provided by the facility directed the nursing staff to: a. Maintain a clean barrier between the equipment and the resident's belongings at all times, b. Remove gloves, wash hands, put equipment away and clean if indicated (if using a community glucose monitor, must disinfect after each use, between resident usage).	F 880		



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F 880	Continued From page 97	F 880		

7. The Admission Record showed the resident #35 admitted to the facility on 2/20/13 with diagnoses of Multiple Sclerosis, lumbar and sacral spina bifida without hydrocephalus.

The Minimum Data Set MDS) Assessment for resident #35, dated 10/10/19, identified a Brief Interview for Mental Status (BIMS) score of 1 indicating severe cognitive loss. The resident required extensive assistance with bed mobility, dressing and personal hygiene. The MDS listed the resident had pressure ulcers present and required pressure reducing devices for the chair, bed, turning, repositioning and pressure wound care.

The Wound/Skin Healing Record, provided by the facility, showed a wound assessment dated 12/9/19 for a stage 3 pressure wound to the left Ischium (pelvic sit bone).

The December 2019 Treatment Administration Record, provided by the facility showed the treatment date of 12/4/2019 instructing nurses to flush the left ischial wound with Dakins Solution, then dampen gauze with Dakins (Solution) and loosely pack in wound. Cover with absorbent dressing every evening shift for stage 3 wound to left ischium.

During observation on 12/18/19 at 2:45 p.m., Staff H, Registered Nurse (RN) set up wound care supplies on a clean barrier. Performed hand hygiene, gloved and placed a towel under the resident's left buttock. Staff H flushed the left ischial wound with Dakins (antiseptic) solution, without changing gloves, took a four inch by four inch piece of gauze and applied Dakins Solution.

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F 880	Continued From page 98 Staff H then used a gloved finger to loosely pack the Dakins soaked piece of gauze into the left ischial wound. Staff H did not change gloves or perform hand hygiene. Staff H applied the clean absorbent dressing over the left ischial wound and secured the dressing with tape still wearing the dirty gloves. During an interview on 12/19/19 at 10:10 a.m., Staff K, Licensed Practical Nurse (LPN), reported she would change gloves after cleansing a wound and after packing a wound before applying a clean wound dressing. During an interview on 12/19/19 at 11:45 a.m., the Interim Director of Nursing (DON) reported the nurses should change gloves and perform hand hygiene after cleaning and packing a wound and before applying a clean wound dressing. The Treatment Protocol, undated, provided by the facility under steps three through five instructed the nurse in the following: 3. Wash hands/put on gloves/remove old dressing and tap and place in a plastic bag and remove gloves. 4. Wash hands/put on gloves/cleanse area as prescribed and remove gloves. 5. Wash hands/put on gloves/complete treatment per physician's order/apply dressing and remove gloves 8. The Minimum Data Set (MDS) Assessment for Resident #44, dated 10/24/19, identified the resident had long and short term memory impairment. The resident required extensive assistance with bed mobility, dressing, toileting and personal hygiene. The MDS listed a	F 880		

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F 880	Continued From page 99 diagnosis of Non-Alzheimer's Dementia and frequently incontinent of urine. During an observation on 12/17/19 at 1:00 p.m., Staff S, Certified Nursing Assistant (CNA) and Staff DD, CNA, transferred the resident to bed. Staff S performed hand hygiene and set up supplies for incontinence care. Staff DD did not perform hand hygiene, removed the dirty attend and proceeded to pick up a wash cloth and cleanse across the abdomen with a wash cloth in the right hand. Staff DD then used the right gloved hand to open the labial folds to cleanse down the labial folds with a wash cloth in the left hand. Staff DD touched the peri-wash bottle with the dirty glove to the right hand and sprayed peri-wash spray to prep the next wash cloth. Staff DD touched the resident's left hip and leg with the dirty gloves to turn the resident onto his/her right side. Staff DD cleansed the left buttock and gluteal fold. Staff DD then touched the clean brief and tucked under the resident's bottom and rolled the resident to his/her back and continued to attach the clean brief with the dirty gloves. Staff DD failed to cleanse the left hip, right hip and full right buttock. During an interview on 12/23/19 at 8:45 a.m., Staff B, CNA reported peri-care would include cleansing the low abdomen, peri-area, buttocks, and hips. During an interview on 12/23/19 at 9:43 a.m. Staff S, CNA, stated during peri care the Low abdomen, peri area, buttocks and hips need do be washed. everywhere the brief touches should be washed. During an interview on 12/23/19 at 9:50 a.m.	F 880		

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F 880	Continued From page 100 Staff H, Registered Nurse (RN), reported proper peri-care would include cleansing front to back the abdomen, peri-area, buttocks and hips. During an interview on 12/23/19 at 11:10 a.m., the Interim DON, reported she expected proper peri-care to include cleansing of all areas the soiled brief touched including the buttocks and hips. She stated a second CNA should hand the CNA performing peri-care clean supplies and assist with positioning the resident during peri-care so the CNA does not touch supplies or the resident with a dirty glove. The undated Perineal Care Policy, provided by the facility failed to address cleansing of the full buttocks, both hips and clean to dirty principles when using gloves during peri-care.	F 880		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the facility failed to appropriately treat 1 out of 2 residents reviewed for a urinary tract infections (Resident # 77). The Facility reported a census of 74 residents.	F 881		

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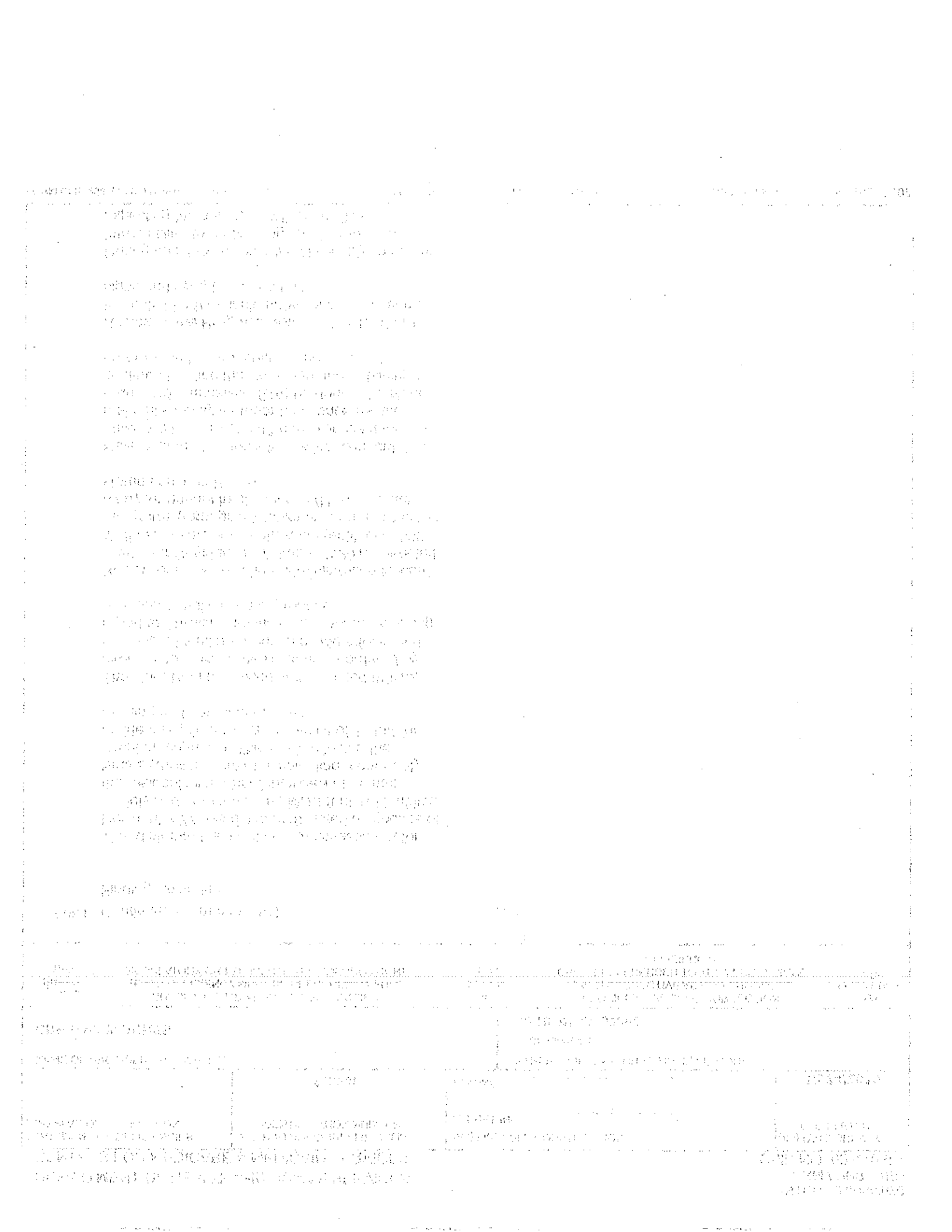
F 881	Continued From page 101 Findings included: The Minimum Data Set (MDS) assessment for Resident # 77 dated 11/22/19, listed diagnoses of anxiety and dementia. The MDS further identified the resident with a Brief Interview of Mental Status (BIMS) score of 8 indicating moderately impaired cognition. The MDS reflected the resident required extensive assist of 1 staff for toileting and personal hygiene. The Care Plan for Resident # 77 dated 8/9/15, directed administer medications as ordered by physician. Monitor for adverse side effects and report to Physician as indicated. Assess calming environment/diversion approaches. Review of the Medication Administration Record (MAR) for Resident # 77 dated 12/2019, directed staff to administer Ciprofloxacin (antibiotic) 500 milligrams (mg), give 1 tablet by mouth two times a day for urinary tract infection (UTI) for 7 days starting on 12/14/2019. Review of the Progress Notes for Resident # 77 dated 12/12/2019 at 2:47 p.m., reflected the resident's family member has concerns and requested a urinalysis (UA) be done. The Note continued calling the Physician and obtaining an order for an UA with culture and sensitivity. Review of the Progress Notes dated 12/12/19 through 12/14/19, lack further documentation of signs and symptoms of a UTI. During an interview on 12/23/19 at 2:55 p.m., the Interim Director of Nursing (DON) reported expecting the nurses to follow the Situation,	F 881		



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F 881	Continued From page 102 Background, Assessment Recommendation (SBAR) for a UTI. The Resident needs to meet the criteria to be placed on an antibiotic. Review of the SBAR Criteria for UTI directed 6/2014, directed without an indwelling catheter criteria are met if one or more of the three situations are met. 1. Acute dysuria (pain with urination) alone. 2. Single temperature of 100 F (38 C) and at least one new or worsening of the following: urgency, frequency, back or flank pain, suprapubic pain, gross hematuria , urinary incontinence. 3. No fever, but two or more of the following symptoms: urgency, frequency,incontinence, suprapubic pain, gross hematuria.	F 881		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, document review and staff interviews the facility failed to maintain an effective pest control program in the kitchen to ensure it remained free of pests. The facility identified a census of 74 residents. Findings include: Observation of the kitchen, during the initial environment tour, on 12/16/19, beginning at 9:30 a.m., revealed the floor around the entire perimeter of the kitchen, had a heavy build up of grime, with scattered dust/dirt, food residue and crumbs, bits of paper waste, etc, with heavier	F 925		

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F 925	Continued From page 103 amounts behind and under equipment. The floor sink for the ice machine drain hoses, approximately 8"X 8"X 6", had a heavy buildup of black grime, mold-like residue and debris covering the majority of surfaces. The floor behind the floor sink showed exposed wood with large open spaces around the hand sink drain and water pipes and the area around the pipes had fine wood chips spread around the area. The floor sink for the dish machine drain, approximately 8" X 8" X 6", had a heavy black grime, mold-like residue and debris covering the majority of the surfaces. The wall around the dishmachine and drain pipes going into the dishmachine floor sink had a buildup of heavy black grime, debris and mold-like residue. The floor under the dish machine had a heavy build up of grime, scattered debris and food crumbs with larger amounts in both corners and around the dish machine chemical cart. The floor at the east end of the dish machine had a pile of fine wood chips in the corner extending toward the east kitchen door. The dish machine chemical cart had scattered dirt, food/beverage splatters and debris on the surface of the cart, with heavier amounts along the front edge. During an interview on 12/16/19, at 10:45 a.m., Staff FF, Dietary Aide, reported he did not know why the wood chips were on the floor and relayed they had been there for about a week or two.	F 925		

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F 925	Continued From page 104 During an interview on 12/16/19, at 10:50 a.m., the Dietary Manager reported the wood chips had been placed there by the maintenance man and were cedar chips. He reported the maintenance man had told him cedar chips may help deter cockroaches. The Dietary Manager reported he has not seen any cockroaches since he became employed in September 2019. Observation on 12/16/19, at 2:45 p.m., revealed a cockroach crawling on the kitchen floor and up onto the east kitchen door. Staff FF saw the cockroach and grabbed a paper towel to catch and dispose of the bug. During an interview at the time, Staff FF, confirmed it was a cockroach and reported they have seen them from time to time in the kitchen. During an interview on 12/17/19, at 8:54 a.m., Staff EE, maintenance, reported he put the cedar wood chips in the kitchen around the hand sink drain and corner of the dish room as a deterrent for the cockroaches about a week ago. During an interview on 12/18/19, 8:00 a.m., the Administrator confirmed the facility's pest control company's last treatment in the kitchen was 11/11/19 and not sure when they were due back. The Dietary Manager reported the pest control company has been coming monthly, so should be coming some time this month. He reported he would check with them to find out when they would be back. During an interview on 12/18/19, at 8:50 a.m., the Administrator reported she has not been in the kitchen since she's been at this facility, other than just inside the door. She acknowledged the multiple environmental concerns and confirmed	F 925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165299	A. BUILDING _____ B. WING _____	12/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW ACRES	1485 GRAND MARION, IA 52302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 105 the lack of routine cleanliness and maintenance issues within the kitchen. During an interview on 12/23/19, 9:20 a.m., the facility's pest elimination service specialist reported he has conducted routine pest management services at the facility. He acknowledged he has not seen any cockroaches in the kitchen for several months, but confirmed it has been an ongoing problem. He reported he has encouraged them to work on sanitation issues in the kitchen, as it can contribute to the harboring of cockroaches but acknowledged he has not noticed any improvement in sanitization, despite the encouragement. The pest elimination specialist also identified other ongoing issues in the kitchen, that can contribute to harboring cockroaches which included the multiple gaps that fail to seal entrance from the walls/floor, which is a prime area for hiding/breeding and the floor drains, especially the dishmachine drain, as it provides a food source. Review of customer service reports from the facility's pest control company revealed the pest elimination specialist recommended the following over the past 3 months: a. Repair of floor tiles/baseboards loose or missing on 10/2/19, 10/14/19, 10/28/19, 11/11/19 and 12/23/19. b. Clean spilled food material found on the floor on 10/2/19, 10/14/19, 10/28/19, 11/11/19 and 12/23/19. c. Floor drains in need of cleaning; need to clean in and around frequently on 10/2/19 and 12/23/19. The report identified these as methods to help prevent pest breeding sites.	F 925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165299	A. BUILDING _____ B. WING _____	12/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW ACRES	1485 GRAND MARION, IA 52302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 106 During an interview on 12/23/19, at 2:30 p.m., the Administrator reported they do not have a general pest control policy to address their pest control program facility-wide, but is currently working on one. The 2013 Food Code, published by the Food and Drug Administration and considered a standard of practice for the food service industry, requires the premises shall be maintained free of insects, rodents, and other pests and the presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the premises by eliminating harborage conditions.	F 925		

This Plan of correction and the individual responses to each F tag are written solely to maintain certification with Medicare and Medicaid programs and as required are submitted as credible allegation of compliance. These written responses do not constitute an admission of noncompliance with any requirement. Crestview Acres wishes to preserve our right to dispute these findings in their entirety should any remedies be imposed and in any legal or administrative proceedings.

F 558 Crestview Acres reasonably ensures that residents reside and receive services in the facility with reasonable accommodations of resident needs and preferences which includes being provided a call light that is accessible to the resident at all times.

- On 12/19/19 Resident #13's call light set up was replaced (added 2nd cord) to accommodate 2 working call lights and rearranged the room to accommodate access of the call light cords.

- All Resident in the facility can be effected.

  A facility wide audit was completed on 01/17/2020 to ensure each individual resident has a functioning call light.

- Facility staff received training on 01/24/2020 and ongoing on the facility call light policy to ensure each individual resident has a functioning call light.

- The Administrator or designee will complete a weekly call light audit which will include each individual resident having access to their own functioning call light for 12 weeks and compliance reviewed at the quarterly QA Meeting.

  Compliance Date: 01/31/2020

F 584 Crestview acres reasonably ensures the residents have a safe, clean, comfortable and homelike environment including the aviary, hallway floors and dining without trays.

- The splatters on the bird cage windows on 400 hall were cleaned and removed.

  The dry brown spots on the floor just inside the door of the Unit and down the hall were cleaned and removed.

  The shoe prints, the brown spots, random splashes, particles of white and brown debris/crumbs, and 7 dark brown spots on the floor in 200 hall dining room were cleaned and removed.

  The residents in the memory care and in the main dining room are no longer eating off trays unless it's a resident preference and documented in their care plan.

- All Resident in the facility may be effected.

  A cleaning schedule and individual assignments were developed for each housekeeper which included the common area floors, aviary, and dining room.

  A designate care taker was identified for the bird aviary and a cleaning schedule was developed for the bird aviary on 400 hall.

  A designated position was created for a floor tech. which includes sweeping, mopping, stripping, waxing, and buffing floors.

- Housekeeping staff and the designated care taker for the aviary received training on 01/24/20 and ongoing on the cleaning schedules (including the bird aviary) and housekeeping assignments.

- The Administrator or designee will complete a weekly clean, and homelike environment audit, which will include the aviary, floors and removing meal trays for 12 weeks and compliance reviewed at the quarterly QA Meeting.

  Compliance Date: 01/31/2020

F 585 Crestview Acres reasonably ensures the residents have a right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. This includes residents and staff being informed about the facility's grievance policy, how to file a grievance, how to f/u on resident concerns, and identify a Grievance Officer.

- The resident Council Meeting was conducted and the residents were informed on how to file a grievance and the Administrator designated as the Grievance Official.

  Resident #60 was informed on how to file a grievance and the Administrator as the Grievance Official.

- All residents have the potential to be effected.

  Then grievance policy was revised to identify the Administrator as the Grievance Official.

  A photo and contact information was posted to identify the Grievance Official and communicate contact information.

  A grievance binder was created to log in grievances and follow up on all correction or actions taken on a resident grievance by the Grievance Official.

- On 01/24/2020 facility staff were educated and ongoing on the Grievance Policy, which includes identifying the Administrator as the Grievance Official, how to file a grievance, and follow up on grievances.

- The Administrator or designee will complete a weekly grievance audit which includes interviewing residents and staff on the grievance process and the follow up on resident grievances for 12 weeks and compliance reviewed at the quarterly QA Meeting.

  Compliance Date: 01/31/2020

F 610 Crestview Acres reasonably ensures it completes a thorough investigation on an allegation of abuse or neglect which includes interviewing the alleged staff involved in the possible abuse in a timely manner.

- Resident #69 no longer resides at the facility.

  On 12/17/2020 the two agency staff were interviewed for the investigation.

- All residents have the potential to be affected.

  An investigation checklist was developed to ensure a thorough investigation is completed.

- On 01/24/2020 the Administrator and DON were educated on requirement F 610 and the investigation checklist.

- The Administrator or designee will complete a weekly audit on abuse and neglect allegation(s) which will include ensuring all (including agency staff) individuals involved in the allegation are interviewed timely for 12 weeks and compliance reviewed at the quarterly QA Meeting.

  Compliance Date 01/31/2020

F 657 Crestview Acres reasonably ensures that each resident has a comprehensive care plan and the care plan is updated quarterly, after each assessment, including, comprehensive, quarterly or with condition changes.

- Resident #63's care plan was updated to include the identification of the rash on resident's abdomen.

  Resident #5's care plan was updated to include the discontinuation of the Foley catheter.

  Resident #44 was re-assed by the nurse and the CNA task list were revised and care plan updated to ensure it matched the assessments.

- All residents have the potential to be effected.

  Completed an audit of care plans and task lists which includes but not limited to ensuring proper identification of rashes, Foleys catheter use, side rails, wander guards and bed alarms

- On 01/24/2020 and ongoing facility Nurse Managers and the MDS Coordinator were educated on updating residents care plans.

  On 01/24/2020 the MDS Coordinator was updated were educated on updating the task list and the care plan on a change in condition.

- The Administrator or designee will complete a weekly audit on care plans revisions to ensure all care plans are updated quarterly, after each assessment, including, comprehensive, quarterly or with a condition change for 12 weeks and compliance reviewed at the quarterly QA Meeting.

  Compliance Date 01/31/2020

F 658 Crestview Acres reasonably ensure it meets professional standards of quality concerning following physician orders which include following a physician order for oxygen and clarifying orders for wound care.

- Physician order for Resident #30's oxygen was reviewed by the Nurse and is receiving oxygen per physician order.

  Physician order and TAR for Resident #35 wound dressing order/instructions was reviewed and clarified by the Nurse and resident is currently receiving her treatments per physician orders.

- All residents have the potential to be effected.

  All residents with an order for continuous oxygen were audited to ensure receiving oxygen per physicians order.

  All residents with wounds were audited to ensure treatment orders and TAR match.

  An order process flow sheet was created to ensure orders are being processed correctly.

- On 01/24/2020 and ongoing Nurses were re- educated on clarifying and following physician orders.

  On 01/24/2020 DON and Nurse Mangers were educated on the order process flow sheet.

- The DON or designee will complete a weekly audit on physician order which will include residents on oxygen and with wounds to ensure professional standard are being maintained for following and clarifying physician orders for 12 weeks and compliance reviewed at the quarterly QA Meeting.

  Compliance Date 01/31/2020

F 689 Crest view Acres reasonably ensures the resident environment remains free of accidents and hazards as is possible and receives adequate supervision and assistance as needed to prevent accidents which includes ensuring chemicals and other hazards are stored behind locked doors.

- The Chemical closet on 100 was fixed to ensure the self- locking mechanism functions appropriately and a sign in place on the door to ensure it is pulled closed and latched/locked.

- All residents have the potential to be effected

  A 100% facility wide audit was completed to ensure all chemicals are being stored away from residents behind a locked door which includes housekeeping closets.

- On 01/24/2020 housekeeping staff were trained on appropriately storing chemical away from residents in the housekeeping closets/carts.

  On 01/24/2020 facility staff were trained on appropriately storing chemicals away from residents.

- The Administrator or designee will complete a weekly audit on chemical storage to ensure away from the residents to ensure all chemicals including the housekeeping closets are secured/locked for 12 weeks and compliance reviewed at the quarterly QA Meeting.

  Compliance Date 01/31/2020

F 692 Crestview Acres reasonably ensures based on comprehensive assessment the facility maintains acceptable parameters of nutritional status such as body weight or desirable body weight range which includes identifying residents with a significant weight loss and providing, evaluation by the dietician and recommendation to the physician.

- Resident #66 was re-evaluated by the dietician, family and physician notified and care plan updated to reflect recommendations. Resident continues to remain within her normal BMI range.

- All residents with a weight loss maybe affected

  A facility wide audit was completed of all residents with a significant weight loss and residents identified will be re-evaluated by the dietician, family and physician notification completed and care plan updated to reflect recommendations.

  A nutrition/hydration action team meeting will be held weekly to review the status of all resident's weight changes, which will include the participation of the Registered Dietician.

  The Restorative aids will be designated to be responsible for completing weights.

- The Dietary Manager, RD, DON/ADON, and Restorative Aides, received education on the Nutrition, Hydration, Action Team Process by 01/07/2020 and ongoing.

- The DON or designee will complete a weekly audit on residents with a weight loss to ensure a significant weight loss is identified, RD evaluation is completed, physician and family are notified along with recommendations updated in the resident care plan for 12 weeks and compliance reviewed at the quarterly QA Meeting.

  Compliance Date 01/07/2020

F 698 Crestview Acres reasonably ensures that residents who receive dialysis receive such services consistent with professional standards of practice which include vital sign checks before and after dialysis treatments, assessment of central port/fistula and weights.

- Resident #5 is being assessed by the nurse which includes her fistula and vitals before and after dialysis treatment.

  Resident #69 no longer resides within the facility.

- Residents receiving Dialysis treatments may be effected

  A facility wide audit was completed of residents receiving dialysis treatments to ensure the completion and assessment of vital sign checks before and after dialysis treatments, assessment of central port/fistula.

  Developed a Hemodialysis Communication Form was developed.

- On 01/24/2020 and ongoing licensed nurses were educated on the Hemodialysis Communication form which included vital sign checks before and after dialysis treatments and assessment of central port/fistula.

- The DON or designee will complete a weekly audit on residents receiving dialysis treatments to ensure vitals are being completed before and after treatments and the central port/fistula is be assessed by a licensed Nurse for 12 weeks and compliance reviewed at the quarterly QA Meeting.

  Compliance Date 01/31/2020

F 710 Crestview Acres reasonably ensures the medical care of each resident is supervised by their attending physician which would include being notified a residents significant weight loss.

- Resident #66 was re-evaluated by the dietician, family and physician notified and care plan updated to reflect recommendations. Resident continues to remains within her normal BMI range.
- All residents with a weight loss maybe affected

  A facility wide audit was completed of all residents with a significant weight loss and residents identified will be re-evaluated by the dietician, family and physician notification completed and care plan updated to reflect recommendations.

  A nutrition/hydration action team meeting will be held weekly to review the status of all resident's weight changes, which will include the Registered Dietician.

- On 01/24/2020 the Dietary Manager, RD, Restorative Aides, DON/ADON were inserviced on the Nutrition/Hydration Process which includes physician notification.

- The DON or designee will complete a weekly audit on residents with a weight loss to ensure a significant weight loss is identified, RD evaluation has been completed, physician and family are notified along with recommendations updated in the resident care plan for 12 weeks and compliance reviewed at the quarterly QA Meeting.

  Compliance Date 01/31/2020

F 741 Crestview Acres reasonably ensures it provides sufficient staff who have appropriate competencies and skills sets to meet behavioral health needs on the licensed Chronic Confusion of Dementia Unit (CCDI), which includes the required 6 hours of Dementia Training.

- Staff LL, V, MM, W, NN have all received a total of 6 hours of dementia training.
- All residents in the CCDI Unit may be effected.

  Identified PAC-T certified trainer (Positive Approach to Care Curriculum and Course Modules) scheduled.

  A flow sheet was developed which tracks completion of the 6 hours of Dementia Training.

  Resume of Program Care was updated to include the need for 6 hours of dementia specific training.

- Facility staff received 6 hours of dementia training on or before 01/31/2020 and ongoing.
- The Administrator or designee will complete a weekly audit on Staff to ensure the completion of 6 hours of dementia training for 12 weeks and compliance reviewed at the quarterly QA Meeting.

  Compliance Date 01/31/2020

F 758 Crestview Acres reasonably ensures residents are free from unnecessary Psychotropic Med/PRN use which includes PRN medication being limited to 14 days unless the attending physician documents the appropriate rationale of the PRN order needing to be extended beyond the 14 days and interventions attempted prior to giving the PRN medications.

- Resident #77's PRN Ativan order was reviewed by attending physician. Physician discontinued the PRN.

- All Residents with a PRN Physician Order for psychotropic drugs may be effected.

  An audit was completed of all residents receiving psychotropic drugs to ensure the medication is limited to 14 days unless the attending physician documents the appropriate rationale of the PRN order needing to be extended beyond the 14 days.

  A Psychotropic Medication PRN Process/Physician Rationale Documentation Form was developed.

- On 1/24/2020 and ongoing Licensed Nurses were educated on the federal requirement F 758 and Psychotropic Medication PRN Process/Physician Rationale Documentation Form.

- The DON or designee will complete a weekly audit on PRN Psychotropic Medication process for 12 weeks and compliance reviewed at the quarterly QA Meeting.

  Compliance Date 01/31/2020

F 759 Crestview Acres reasonably ensures its medication error rates do not exceed 5% or greater which includes properly priming the insulin flex pens for the administration of insulin.

- Resident #6 is receiving the proper dose of the physician order of insulin by priming the insulin flex pens prior to insulin administration. (Note: Resident #6 does not appear on the sample list provided to the facility. Based on review of MAR/TAR's and specific order mentioned in 2567 it appears to be another resident not mentioned in the sample list).

  Resident #30 is receiving the proper dose of the physician order of insulin by priming the insulin flex pens prior to insulin administration.

- All resident receiving insulin administration using the insulin flex pen may be effected.

  A facility wide audit was completed to insert instructions on the MAR to prime the insulin pen prior to administration for all resident who are using the flex pens for the administration of insulin.

  A flex pen proficiency tool was developed to demonstrate competency for the licensed nurses to be completed by 01/24/2020.

- On 01/24/2020 and ongoing facility Nurses were educated on the manufactures recommendation of the administration of insulin which includes priming the pen prior to the administration of the insulin.

- The DON or designee will complete a weekly audit on appropriate use of the flex pens which will include priming the pens prior to administration for 12 weeks and compliance reviewed at the quarterly QA Meeting.

  Compliance Date 01/31/2020

F 801 Crestview Acres reasonably ensures the facility employs sufficient staff with the appropriate competencies and skill sets to carry out the functions of the food and nutritional services which includes employing a qualified person to serve as the Director of Food and Nutrition Services in the absence of a full time dietician to ensure sufficient scheduled consultations from a qualified Dietician to provide adequate oversight and support to the department.

- Dietary Manager is currently enrolled in the CDM certification course.

  Dietary Manager is currently enrolled in a Certified Food Protection Program (Serve Safe)

- All residents have the potential to be effected.

  The Dietician completed a kitchen inspection on 01/14/2020.

  The Registered Dietician will observe at least one meal observation a kitchen sanitation inspection, as well as performance of Dietary staff throughout these observations The Registered Dietician will also provide feedback based on observation to the Dietary Manager, Dietary Staff and Administrator.

  Dietary Manager will provide routine updates on progress.

- By or before 01/24/2020 and ongoing the Dietary Manager will be in-serviced on facility menus, spreadsheets meal service, and therapeutic diets.

  By 01/24/2020 the dietician was educated on her responsibilities under the Consulting Dietician Agreement to the facility to observing meal preparation and recommend changes as needed, develop and present in-service education, assist in developing managerial and supervisory skills of facility food service department supervisor through on the job education.

- The Administrator designee will complete a weekly audit on the progress the Dietary Manager is in completing the CDM course as well as the Dieticians oversight which includes at least one meal observation a kitchen sanitation inspection, as well as performance of Dietary staff throughout these observations and that the Registered Dietician will also provide feedback based on observation to the Dietary Manager Dietary Staff and Administrator for 12 weeks and compliance reviewed at the quarterly QA Meeting.

  Compliance Date 01/31/2020

F 803 Crestview Acres reasonably ensures the facility menu meets the nutritional needs of the residents and are being followed which includes pureed portions being measured, correct portioning utensil being utilized when serving, and correct menu items being available.

- The menu is being followed for all residents and those residents on pureed and mechanical soft diets are receiving the correctly measured portions.

- Staff HH and Dietary Manager have has been educated on following the menu, pureed preparation and portioning process (pureed diet portion chart), textured diets mechanical soft..), therapeutic diets and portion sizes, utensils (scoops, spoodles) menu spread sheets

- All residents have the potential to be effected including those on pureed and mechanical soft diets

  An audit was completed to ensure all menu spreadsheets were available for the menu cycle

  An order was placed to ensure utensil necessary for portion sizes are available.

  A pureed process was developed.

- On 01/24/2020 facility cooks and Dietary Manager were inserviced on following the menu, pureed preparation and portioning process (pureed diet portion chart), textured diets mechanical soft..), therapeutic diets and portion sizes, utensils (scoop, spoodle) menu spread sheets.

- The Administrator or designee will complete a weekly audit on following the menu which includes pureed process and portions being measured, correct portioning utensil being utilized when serving, and correct menu items being available for 12 weeks and compliance reviewed at the quarterly QA Meeting.

  Compliance Date 01/31/2020

F 804 Crestview Acres reasonably ensures food items are prepared by methods that conserve nutritive value, flavor and appearance and food and drink that is palatable attractive and at a safe appetizing temperature which includes offering condiments with room trays, providing alternatives such as soup or ice cream, and a variety of snack options.

- All residents receiving room trays are being delivered food items that are prepared by methods which conserve nutritive value, flavor and appearance and food and drink that is palatable attractive and at a safe appetizing temperature which includes offering condiments alternatives (soup or ice cream), snacks.

  Staff HH and the Dietary Manager have received training on requirement F 804, the room tray process, food and beverage temperature process, and the always available menu.

- All residents have the potential to be effected including receiving a room tray.

  A room tray process was developed which include condiment items being available and menu items being served at palatable temperatures.

  A food and beverage temperature process was developed which includes temping all menu items before service, room trays, and test trays.

  An always available menu was created which includes breakfast, lunch, dinner, and snacks which includes chicken noodle soup and ice cream.

- On 01/24/2020 dietary staff and Dietary Manager were educated on requirement F 804, the room tray process, food and beverage temperature process, and the always available menu which includes food and drink that is palatable attractive and at a safe appetizing temperature, offering condiments with room trays, alternatives such as soup or ice cream being available, and providing HS snacks.

- The Administrator or designee will complete a weekly audit on food items that are prepared by methods that conserve nutritive value, flavor and appearance and food and drink that is palatable attractive and at a safe appetizing temperature which includes offering condiments with room trays, alternatives such as soup or ice cream, and snack options for 12 weeks and compliance reviewed at the quarterly QA Meeting.

  Compliance Date 01/31/2020

F 809 Crestview Acres reasonably ensures each resident must receive at least 3 meals daily at regular times and that there is no more the 14 hours between a substantial evening meal and breakfast the following day except when a nourishing snack is served at bedtime, up to 16 hours may lapse between dinner and breakfast the following day, which includes offering bed time snacks.

- Resident #13 is being offered a bed time snack.

  The 5 interviewable residents are receiving a bed time snack.

- All residents have the potential to be effected.

  A bed time snack process was developed to ensure all residents are being offered an HS snack.

  Meal times were reviewed to ensure there is no more the 14 hours between a substantial evening meal and breakfast the following day

- On 01/24/2020 dietary and nursing staff were educated on the bed time snack process and meal times.

- The Administrator or designee will complete a weekly audit on resident to ensure they receive at least 3 meals daily at regular times and that there is no more the 14 hours between a substantial evening meal and breakfast the following day which includes serving a bed time snack except when a nourishing snack is served at bedtime for 12 weeks and compliance reviewed at the quarterly QA Meeting.

  Compliance Date 01/31/2020

F 812 Crestview Acres reasonably ensure it stores, prepares distributes food in accordance to reasonable standards which includes maintaining the kitchen in a clean and sanitary manner, maintaining food contact surfaces in a clean condition, ensuring the dish washer meets manufacturers and regulatory requirements and food is served under sanitary conditions to reduce risk of food and food-borne illnesses.

- The hand washing sink with the soiled rag was cleaned and rag laundered.

  The wall, pipes, and the floor behind and around the ice machine was cleaned.

  The lower wall behind the dish machine and dish machine tables, and the horizontal drain pipes under the dish machine. The portion of the walls above the soiled end of the dish machine table extending upward approximately 3 feet, the east kitchen door by the dish machine extending upward about half way, the wall to the left was all cleaned of splatters and free of soiled debris. The rust on hinges of door way was corrected.

  The top and front of the dish machine extending up to and around the chemical squeeze pumps was cleaned.

  The wooden cabinets on the north kitchen wall were removed, discarded, and replaced.

  A utility drawer and all the wood cabinets to the left of the steam table was removed and discarded and replaced with a stainless steel alternative.

  The kitchen ceiling consisting of medium-textured ceiling tiles, were be replaced with a non-porous cleanable surface.

  The south wall soffit, above the chemical room door trim was repaired.

  The walk-in refrigerator floor was cleaned and all debris was removed. The hard boiled eggs discarded. Resident food items were removed from the refrigerator. An unlabeled undated zip lock bag with the unpleasant order was discarded. The slice of pizza, 5# packages of shredded Swiss cheese, 5# package of shredded mozzarella cheese, 5# package of sliced white American cheeses, 1 16oz opened black cherry Plus Two supplements. 22 4 oz. chocolate might shakes opened without dates were discarded.

  The walk-in freezer floor was cleaned. The build- up of ice on ceiling, at the back near the freezer coils/fans and on the top left along with the shelf are free of ice. The freezer door sill was cleaned and the degraded metal and rust was repaired.

The two 6# rolls of Farmland pork sausage and box sitting next to the bus tub which contained 4-5# packages of ground beef are not present. Currently meat is being thawed under refrigeration.

The counter top on the north wall cabinets, to the right of the steam table were removed and discarded. The wall above the counter top was cleaned. The counter top above the steam table and the strip attached to the entire length of the counter top was removed and discarded with stainless steel surface.

The cooks table next to the stove, steam table pans. The pans on the bottom shelf were cleaned along with the edge of the shelf.

The counter on the west wall cove base and quarter round was repaired and debris cleaned to create a seamless surface. Then caulk was replaced.

The west wall above the metal table was cleaned.

The large plastic tray and silverware cart was discarded.

A thermometer was placed in the walk-in refrigerator to document temps.

The dish washer was replaced with a new machine so appropriate temperatures could be maintained.

Chlorine test strips were ordered and currently in use to test the chlorine concentration of the chemical.

Temperatures are currently being taken of the cold and hot food and recorded in the food temp log. Hot food temps are being held in the steam table and cold food temps (including required cold snack items) are being maintained under refrigeration or an ice bath.

Staff II is washing hands before and after using disposable gloves, using gloves for designated food tasks only, using gloves that are task specific and washing hands between glove changes.

The drink glasses, dessert dishes/cups, dressing cups, on the unit and on room trays are being covered during transport.

The bulk container of sugar in the dry storage area remains covered.

- All residents have the potential to be effected

The Registered Dietician will observe at least one meal observation and complete a kitchen sanitation inspection, which includes maintaining the kitchen in a clean

and sanitary manner, maintain food contact surfaces in a clean condition, ensure the dish washer met manufacturers and regulatory requirements, and serve food under sanitary conditions to reduce risk to food and food-borne illnesses.

DHHS/CMS pathway kitchen observation tool is now being used for inspections.

Cleaning schedules were reviewed and revised.

- On 01/24/2020 dietary staff and Dietary Manager were educated on preparing and distributing food in accordance to reasonable standards, maintaining the kitchen in a clean and sanitary manner, maintain food contact surfaces in a clean condition, ensure the dish washer meets manufacturers and regulatory requirements, and serve food under sanitary conditions to reduce risk to food and food-borne illnesses. In addition department education includes hot food temps are being held in the steam table and cold food temps (including required cold snack items) are being maintained under refrigeration or an ice bath, dish washer test strips, glove-ology (addresses handwashing and glove usage) covering food/beverage items during transport, covering and disposing items in the freezer, refrigerator, or dry storage areas, revised cleaning schedules, labeling/dating items, disposing of items past used by or expiration date in the refrigerator/freezer, freezer and dry storage.

- The Administrator or designee will complete a weekly audit to ensure the dietary department stores, prepares distributes food in accordance to reasonable standards which includes maintaining the kitchen in a clean and sanitary manner, maintaining food contact surfaces in a clean condition, ensuring the dish machine meets manufacturers and regulatory requirements and food and beverages are served under sanitary conditions to reduce risk of food and food-borne illnesses for 12 weeks and compliance reviewed at the quarterly QA Meeting.

Compliance Date 01/31/2020

F838 Crestview Acres reasonably ensures that it has a complete and accurate facility assessment to assess what staff and resources are needed for both day to day operations as well as emergent situations.

- Administrator and DON has been updated in the most recent version of the facility assessment on 1-22-20.

  Governing body, medical director, and other key staff have been updated in most recent version of the facility assessment on 1-22-20.

  The facility's CCDI unit has been identified and updated on 1-22-20.

- All residents may be affected including residents in the CCDI unit.

  The facility assessment will be updated in January of each year, and as needed based on staffing changes and needs of the facility.

  The administrator or designee will send updated facility assessments at least every January (and as needed) to the governing body for review and accuracy.

- The current administrator has been trained on QHC's version of the facility assessment on 1-15-20.

- The facility assessment will be audited weekly for 12 weeks then reviewed for compliance and the quarterly QAPI/QA meeting.

Compliance Date: 1-31-20

- F880 Crestview Acres reasonably ensures that there is an effective Infection Control program to include preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals.

- Staff OO transported laundry in an uncovered basket and laundry cart with clean laundry down the hall. Laundry basket liners and covers have been ordered and all flaps are down on laundry carts when transporting laundry down the hall and room to room.

  A trash bin sat next to the dirty laundry bin which was within 3 inches of the open clean laundry cart. Staff now ensure that dirty bins and clean laundry are more than 6 feet or more away from soiled items.

  A CNA walked out of resident room carrying an un-bagged large handful of urine smelling laundry. CNAs now bag all soiled items in trash bags before leaving the room then place them directly in the soiled linen bin located in the hall closest to them.

  Housekeeping staff sprayed a table in the unit with spic and span foam cleaner and immediately wiped the chemical off with a white towel. Housekeeping now reads the directions on the bottle and may also reference chemical 'cheat sheet' to ensure proper usage of chemicals for disinfecting surfaces in all areas of the facility.

  During an observation it was observed a resident sat in their wheelchair with the drainage bag laying on the floor and uncovered. All bags now have a cover and are hung below the bladder on their chair.

  During an observation it was observed that a resident laying supine in bed had their urinary drainage bag laying on the floor and uncovered. Drainage bag is now covered and is hung below the bladder on the bed covered with no part of the drainage bag or tube touching the ground.

  An undated catheter care policy did not address the use of privacy bags for dignity or direct staff to keep the urinary drainage bags from contacting the floor to prevent infection. Policy has been updated to include this instructions.

  During personal care it was observed a CNA assisted resident #8 to their room and to the bathroom. Staff BB gloved without performing hand hygiene, opened

the urinary leg drainage bag valve and emptied the contents into a graduate. Graduate was set directly on the floor without a clean barrier. CNAs now place a clean barrier between the graduate and the floor to prevent infection. CNAs now perform hand hygiene before placing gloves on their hands.

The undated catheter drainage/ specimen collection policy did not direct the nursing staff on using a clean barrier before setting the graduate on the floor to prevent infection. The policy has been updated to include using a barrier to prevent infection.

It was observed that staff W (OMT) performed a blood sugar check using an accu-check. Staff W laid the blood glucose monitor on the resident's bed, also directly on the medication cart, and also on dirty bed linen without a barrier. Staff Y placed the blood glucose machine on the nurses' desk then on the medication cart without a clean barrier. Staff now uses a barrier between the dirty surface and the accu-check when setting the accu-check down.

Staff W (OMT) and Staff Y cleaned the blood glucose monitor using alcohol pads. Staff now use sani wipes and follows the glucose machine policy/ procedure to clean accu-checks.

It was observed that staff H (RN) set up wound care supplies and performed a treatment without changing her gloves after flushing a wound and going to a sterile pad to dress the wound and completed the dressing without changing gloves. Nursing now understand the hand hygiene policy and performs hand hygiene when changing gloves when going from a dirty surface to a clean/ sterile surface.

It was observed that CNA DD completed peri care without changing gloves going from a dirty surface to a clean surface. It was also observed she did not perform complete peri care as evidenced by not washing any skin surface the brief had touched. Nursing staff now understand the peri care and hand hygiene/ glove changing protocol and perform it correctly.

- All residents may be affected to include residents with indwelling catheters and residents with diabetes whose blood sugars need to be checked.

  Housekeeping, laundry staff, and nursing staff were reeducated that all laundry carts and laundry basket should be covered with nothing stacked on top while

being transported and in common areas such as hallways or lounges on 1-24-20 and ongoing.

Housekeeping and CNAs were educated on the proper use of chemicals to include instructions for specific chemicals frequently used to clean surfaces on 1-24-20 and ongoing.

Nursing staff were educated on treatment of soiled linens and items during resident cares on 1-24-20 and ongoing.

Housekeeping and nursing staff were reeducated on the requirements for proximity of dirty and soiled linens on 1-24-20 and ongoing.

Nursing staff were educated on the catheter care policy and procedures, use of privacy bags, emptying, and cleaning catheter bags on 1-24-20 and ongoing to ensure it is being emptied and cleaned properly.

Nursing staff were educated on proper hand hygiene and protocol to include hand hygiene while performing cares and treatments to include hand hygiene when going from touching a dirty surface to a clean surface on 1-24-20 and ongoing.

The catheter drainage/specimen collection policy was updated and nursing staff retrained to the updated policy to include using a clean barrier before setting a graduate on the floor to prevent infection on 1-24-20 and ongoing.

Nursing staff were reeducated on the proper use of glucose monitors to include laying a barrier down between a dirty surface and the glucose monitor while performing a blood glucose check as well as the proper sanitization of the glucose monitors on 1-24-20 and ongoing.

CNAs were reeducated on hand hygiene while performing cares on 1-24-20 and ongoing.

CNAs were reeducated on performing peri care to include washing the full hip or anywhere the brief has touched the skin to prevent infection on 1-24-20 and ongoing.

- Administrator or designee will audit staff transporting laundry weekly for 12 weeks.

  Administrator or designee will audit staff cleaning surface that include chemical to ensure they are being used properly to ensure proper sanitization weekly for 12 weeks.

  DON or designee will audit resident cares to ensure soiled linens, and proper glove and hand washing procedures are performed correctly weekly for 12 weeks.

  DON or designee will audit catheter care, and use of privacy catheter care weekly for 12 weeks.

  DON or designee will audit hand hygiene during CNA cares and ongoing weekly for 12 weeks.

  DON or designee will audit hand hygiene while performing nursing treatments weekly for 12 weeks.

  DON or designee will audit glucose checks weekly for 12 weeks.

  DON or designee will audit peri care weekly for 12 weeks.

  Compliance Date: 1-31-20

F881 Crestview Acres reasonably ensures that the antibiotic stewardship program is in place and is being effectively used by ensuring an SBAR is completed before a patient is placed on antibiotics.

- Resident #77 is currently not on any antibiotics and UTI has been resolved.

  Situation, Background, Assessment, Recommendations (SBAR) are to be completed on anyone who may need an antibiotic, and further documentation regarding the infection is expected per protocol.

- Any resident with a possible infection that may require antibiotics.

  Facility antibiotic stewardship and process has been created to clarify steps for nursing staff.

  Facility medical director has signed off on facility antibiotic stewardship process on 1-24-20.

  SBARs are still available to all nurses and are placed at every nurse's station.

  Developed an alert charting process which would include symptoms of an infection

  Antibiotic stewardship form developed.

- Nurses were reeducated during a nursing meeting on 1-16-20 and ongoing on the antibiotic stewardship program to include the criteria, causes for infection, and how to use SBAR.

  Nurses were reeducated during a nursing meeting on 1-16-20 and ongoing on alert charting process and documentation process for residents placed on the 24 hour/ alert charting binder to continue to monitor for infection.

- The DON or designee will complete a weekly audit to check faxes and alert charting during grand rounds to ensure SBARs have been completed and the facility's process has been followed.

Compliance Date: 1-31-20

F 925 Crestview Acres reasonably ensures that there is an effective pest control program so that the facility is free of pests and rodents within the facility. This includes cleanliness in the kitchen which would be free of grime buildup, scattered dust/ dirt, food residue and crumbs on working areas and floors and ensured that they are cleaned each shift.

- The heavy buildup of grime, scattered dirt/ dust, food crumbs, and bits of waste on the floor and working areas were cleaned or removed.

  The floor sink with grime and heavy buildup and debris covering most of the areas along with the floor below the handwashing sink had an open area and fine wood chips, as well as buildup covering most of the surfaces were cleaned and removed.

  The wall around the dish machine and drainpipes going into the dish machine that had a residue build up that encompassed most of the area was cleaned.

  The dish machine chemical cart had food/ beverage debris and splatters were cleaned and removed.

  The recommendations from the pest control company to repair floor tiles/ baseboards that were loose or missing, cleaning food material found on floor, and floor drains cleaned to aide in prevention and reduction of pests in the kitchen dates were completed and corrected.

- All residents have a potential to be affected.

  All cleaning lists have been updated by the dietary manager and reviewed by the Administrator.

  Regular deep cleaning schedule has been developed and staff mandated to attend monthly deep cleaning.
  Maintenance director will make weekly rounds in the kitchen to ensure there are not any maintenance needs.

  Dietary and maintenance staff will follow through with recommendations of pest control company and will be signed off.

Dietary director and administrator will meet weekly on 1:1 times to go over recommendations from dietician and pest control professionals and follow through with recommendations.

Weekly kitchen inspections will be completed by the Registered Dietician.

Recommendations will be checked that they are completed and signed off by the dietician and administrator.

- The dietary manager received training on 1-24-20 on the pest control protocol in the kitchen to ensure cleanliness and pest control management.

  Dietary staff were all inserviced on cleaning schedules as well as the pest control policy on 1-24-20 and ongoing.

- The Administrator or designee will complete a weekly cleanliness and pest control audit for 12 weeks and compliance reviewed at the quarterly QA meeting.

Compliance Date: 1-31-20